

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/6D

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8035 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 7 Film 6292 8/1/61 18027											
1. PLACE OF DEATH e. COUNTY <i>Harford</i> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Joppa</i> g. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Franklinville Road</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <i>md</i> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>White Marsh</i> g. STREET ADDRESS <i>03X-2</i>				3. DATE OF DEATH Month <i>July</i> Day <i>18</i> Year <i>1961</i>			
4. NAME OF DECEASED (Type or print) <i>Everett C Berry</i>				5. SEX <i>M</i>				6. COLOR OR RACE <i>W</i>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				8. DATE OF BIRTH <i>6-4-13</i>				9. AGE (In years last birthday) <i>48 yrs.</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>Virginia</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>				13. FATHER'S NAME <i>Lee Berry</i>				14. MOTHER'S MAIDEN NAME <i>Steda Sick</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <i>219-01-4001</i>				17. INFORMANT <i>JUDITH BLACK (SISTER)</i> Address <i>1100 N. Balto. St.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pending Poisoning due to CO</i> 894.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Went down in well + died</i>							
20c. TIME OF INJURY Month, Day, Year Hour e.m. <i>7-18-61</i>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> et work et work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Farm</i>			
20f. (City or town) <i>Joppa</i> (County) <i>Harford</i> (State) <i>md.</i>				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				22b. DATE THEREOF <i>7-21-61</i>				22c. NAME OF CEMETERY OR CREMATORY <i>Balto. National</i>			
22d. LOCATION (City, town, or country) <i>Balto. Md.</i>				23. FUNERAL DIRECTOR <i>John G. Connelly 418 Eastern Blvd.</i> ADDRESS							
24a. REC'D BY REGISTRAR <i>Arthur S. Kline</i> DATE <i>JUL 27 '61</i>				24b. REGISTRAR'S SIGNATURE							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

8035

08023

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Edgewood</u>	
3. NAME OF DECEASED (Type or print) <u>Baby</u> First <u>GIRL</u> Middle <u>Bojanowski</u> Last		4. DATE OF DEATH Month <u>7</u> - Day <u>14</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/14/61</u>
9. AGE (In years last birthday) yrs. <u>15</u>		10. IF UNDER 1 YEAR Months <u>15</u> Days <u>15</u> Min. <u>15</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph Bojanowski</u>		14. MOTHER'S MAIDEN NAME <u>Claire Wonderly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Joseph Bojanowski</u>		Address <u>Edgewood Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure.</u> 76215 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary atelectasis</u> DUE TO (c) <u>Prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/14/61</u> to <u>7/14/61</u> , that (I) (we) last saw the deceased alive on <u>7/14/61</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William M. Leen</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>7/17/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>William M. Leen</u>		22d. ADDRESS <u>600 S. UNION AVE HARREDEGRACE MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 18, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Francis</u>		23d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McBratney</u>		25a. REC'D BY REGISTRAR <u>JUL 20 61</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Robert S. McBratney</u>			

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2803

CERTIFICATE OF DEATH

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James M. Smith

James M. Smith

James M. Smith

James M. Smith

James M. Smith

James M. Smith

James M. Smith

James M. Smith

James M. Smith

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VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08023

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hambleton</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hambleton Rural</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		4. DATE OF DEATH <u>July 26, 1961</u>	
3. NAME OF DECEASED (Type or print) <u>Carl Brandauer</u>		5. SEX <u>Male</u> COLOR OR RACE <u>White</u>	
6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DATE OF BIRTH <u>Nov. 11, 1892</u>		7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. AGE (In years, lost birthday) <u>68</u> yrs.		9. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automotive</u>	
11. BIRTHPLACE (State or foreign country) <u>Vienna Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Carl Brandauer</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Fernau</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>382-16-4141</u>	
17. INFORMANT <u>Mr Carl Brandauer</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - State</u> DUE TO <u>Hambleton Md R10</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart failure</u> DUE TO <u>1 year</u> (c) <u>Cerebro Sclerosis</u> DUE TO <u>5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 Previous Cerebro Vascular Accidents</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 12, 1950</u> to <u>July 26, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 25, 1961</u> , and that death occurred at <u>7 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Dudley Phillips MD</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>		22d. ADDRESS <u>DARLINGTON, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 27, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Med. School</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Bailey</u>		25a. REC'D BY REGISTRAR <u>JUL 28 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>		25c. ADDRESS	

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DEPARTMENT

RECORDS

CHIEF CLERK



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

8038

08020

1. PLACE OF DEATH e. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Stave de Grace</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Stave de Grace</i>	
c. LENGTH OF STAY in 1b <i>about 20 yrs.</i>		d. STREET ADDRESS <i>464 Alliance Street</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Harford Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mamie Rebecca Brown</i>		4. DATE OF DEATH Month Day Year <i>7 12 1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 23, 1903</i>
9. AGE (In years last birthday) <i>58</i> yrs.		IF UNDER 1 YEAR Months Days <i>3 19</i>	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Harford County, Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>David Kennard</i>	
14. MOTHER'S MAIDEN NAME <i>M. Rebecca Butler</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	
16. SOCIAL SECURITY NO. <i>218-07-7309</i>		17. INFORMANT Address <i>Mr. Walter Brown, Stave de Grace, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <i>Adams-Stokes Syndrome</i> DUE TO (c) <i>Hypertensive-Arterio-sclerotic Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>June 7, 1961</i> to <i>July 12, 1961</i> , that (I) (we) last saw the deceased alive on <i>July 12, 1961</i> , and that death occurred at <i>8 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>George T. Stansbury</i> M.D.		22b. DATE SIGNED <i>7/14/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>		22d. ADDRESS <i>569 Revolution St. Havre de Grace, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>July 15, 1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Union Methodist Cem.</i>	23d. LOCATION (City, town or county) (State) <i>Aberdeen, Harford Co., Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Clifford J. Bullock - Stave de Grace, Md.</i>		25a. REC'D BY REGISTRAR <i>Jul 17 '61</i>	25b. REGISTRAR'S SIGNATURE <i>Clifford J. Bullock</i>

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

10/15/77

M. J. ...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8039

08031

|  |   |  |                                      |
|--|---|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Hartford</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b><br>c. LENGTH OF STAY IN b <b>1 day</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Hartford Memorial</b> |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md</b><br>b. COUNTY <b>HARTFORD</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>X Street</b><br>d. STREET ADDRESS <b>Burkins Rd &amp; Miller Rd</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                      |
| 3. NAME OF DECEASED (Type or print) <b>Baby</b><br>First <b>Carico</b> Middle <b>Carico</b> Last <b>Carico</b>   |   | 4. DATE OF DEATH <b>7 3 1961</b>   |                                      |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>W</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>7-2-61</b>       |
| 9. AGE (In years last birthday) <b>8 6</b>   |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>   |                                      |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Havre de Grace</b>  |   | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |                                      |
| 13. FATHER'S NAME <b>George Samuel Carico</b>  |   | 14. MOTHER'S MAIDEN NAME <b>Irene Freeman</b>  |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |   | 16. SOCIAL SECURITY NO. <b>—</b>   |                                      |
| 17. INFORMANT <b>GEORGE S. CARICO</b>  |   | Address <b>STREET MD.</b>  |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (e) <b>Perinatal - BX ut. 3'3"</b><br>774X<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. }<br>DUE TO (b)<br>DUE TO (c)   |   | INTERVAL BETWEEN ONSET AND DEATH   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)   |   |  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY<br>Hour a.m. <b>19</b><br>p.m.   | 20d. INJURY OCCURRED<br>While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7/2 1961</b> to <b>7/2 1961</b> , that (I) (we) last saw the deceased alive on <b>7/2 1961</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.  |   |  |                                      |
| 22a. SIGNATURE <b>J. H. Hatten</b>   |   | 22b. DATE SIGNED <b>7/4/61</b>   |                                      |
| 22c. PHYSICIAN'S NAME (Type) <b>J. H. Hatten</b>   |   | 22d. ADDRESS   |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |   | 23b. DATE THEREOF <b>7/5/61</b>  |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Ayres Chapel</b>   |   | 23d. LOCATION (City, town or county) (State) <b>White Hall, Maryland</b>   |                                      |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles C. Hunt</b>  |   | 25a. REC'D BY REGISTRAR <b>JUL 6 '61</b>   |                                      |
| ADDRESS <b>Jarrettville</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>  |                                      |

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Hartford

House of Representatives

Hartford, Connecticut

1864

Frank W.

George Samuel Carico

House of Representatives

Frank Freeman

SECRET

Carico

11-2-61

USA

NY

Street

Franklin D. Roosevelt

11-2-61

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08032

|   |                               |   |                                      |
|---|-------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Hartford</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>                 |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>  |                               | c. LENGTH OF STAY IN 1b <u>23 days</u>  |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>  |                               | d. STREET ADDRESS <u>1 Box 285</u>  |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Willard</u> Middle <u>G.</u> Last <u>Carr</u>   |                               | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>26</u> Year <u>1961</u>  |                                      |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 6, 1891</u> |
| 9. AGE (In years last birthday) <u>70</u> yrs.  |                               | IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXXX Landscape Gardener</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>   |                                      |
| 11. BIRTHPLACE (State or foreign country) <u>USA.</u>   |                               | 12. CITIZEN OF WHAT COUNTRY <u>USA.</u>   |                                      |
| 13. FATHER'S NAME <u>ELMER ? E. Carr</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>ANNIE DELEVETT</u> <u>XXXXX</u>   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                               | 16. SOCIAL SECURITY NO. <u>  </u>   |                                      |
| 17. INFORMANT <u>Hazel G. Carr, Forest Hill, Maryland</u>   |                               | Address <u>  </u>   |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>422</u> DUE TO <u>ASCOD - C.U.Q.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Failure</u> (c) <u>  </u> |                               | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ca cancer</u>  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>  </u> <u>  </u> <u>19</u>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>    |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)  |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 3, 1961</u> , to <u>July 26, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 26, 1961</u> , and that death occurred at <u>9:35</u> A.M. from the causes and on the date stated above.                                     |                               |   |                                      |
| 22a. SIGNATURE <u>William K. Brendle</u> M.D.   |                               | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 7-27-61 22b. DATE SIGNED    |                                      |
| 22c. PHYSICIAN'S NAME (Type) <u>William K. Brendle, M. D.</u>   |                               | 22d. ADDRESS <u>608 S. Union, Havre de Grace, Md.</u>   |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 23b. DATE THEREOF <u>7/28/61</u>  |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Deer Creek Cemetery</u>   |                               | 23d. LOCATION (City, town, or county) (State) <u>Forest Hill, Maryland</u>  |                                      |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u> ADDRESS <u>Tarring Funeral Home, Aberdeen, Md.</u>  |                               | 25a. REC'D BY REGISTRAR DATE <u>JUL 31 '61</u>  |                                      |
| 25b. REGISTRAR'S SIGNATURE <u>Carlton L. Farris</u>   |                               |   |                                      |



1  
FOR STATE  
HEALTH DEPT.  
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TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

8041  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
08033

|  |                              |   |  |  |                                |   |  |
|--|------------------------------|---|--|--|--------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND   |                              |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>e. STATE <u>Penn</u> b. COUNTY <u>Lancaster</u> |                                |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Harrods Trace</u>   |                              | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Acron</u> <u>ROTHSVILLE</u>                       |                                |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>←</u>   |                              |   |  | d. STREET ADDRESS<br><u>NONE</u> <u>75X-2</u>  |                                | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Raymond</u> First <u>Carvell</u> Middle Last   |                              |   |  | 4. DATE OF DEATH <u>July</u> <u>27</u> <u>1961</u> Month Day Year  |                                |   |  |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><u>1931</u><br><u>APRIL 20</u> <u>1931</u> | 9. AGE (In years last birthday)<br><u>30</u> yrs.  | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS.<br>Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>SALES MAN</u>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>PENNA.</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>U.S.A.</u>   |                                | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>MONROE W. CARVELL</u>  |                              |   |  | 14. MOTHER'S MAIDEN NAME<br><u>ANNIE LAUSCH</u>  |                                |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>Unknown</u>  |                              | 16. SOCIAL SECURITY NO.<br><u>Unknown</u>   |  | 17. INFORMANT<br><u>MONROE W. CARVELL, ROTHSVILLE, PA.</u>   |                                |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia due to drowning</u><br>929-8<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. }<br>(b) _____<br>(c) _____<br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH _____ |                              |   |  |  |                                | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Drowned in Susquehanna River</u>                         |  |  |                                |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><u>3</u> Hour <u>7-26</u> <u>1961</u> p.m.  |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Susquehanna River Harrods Trace - Md.</u>                   |                                | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |                              |   |  |  |                                |   |  |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.   |                              |   |  | CHIEF MEDICAL EXAMINER <u>Bella</u> <u>rd</u>  |                                |   |  |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer md</u>   |                              |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-27-61</u>   |                                |   |  |
| 22a. NAME OF CEMETERY OR CREMATORY<br><u>LOTHERAN CEMETERY</u>   |                              |   |  | 22b. LOCATION (City, town, or country) (State)<br><u>ROTHSVILLE, LANCO, PENNA.</u>   |                                |   |  |
| 23. FUNERAL DIRECTOR<br><u>Blanchard &amp; Co. Harrods Trace</u>   |                              |   |  | 24a. REC'D BY REGISTRAR<br><u>DATE JUL 31 '61</u>  |                                |   |  |
|  |                              |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>William S. Hanna</u>  |                                |   |  |





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8042 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08034

|   |                           |   |                                       |
|---|---------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Harford</u>  |                                       |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>   |                           | c. LENGTH OF STAY in 1b <u>28 years</u>   |                                       |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Tull Gate Road</u>  |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                       |
| 3. NAME OF DECEASED (Type or print) <u>Alice Ann Chambers</u>   |                           | 4. DATE OF DEATH <u>7-12</u> 19 <u>61</u>   |                                       |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>Oct. 17, 1879</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>   |                           | 11. BIRTHPLACE (State or foreign country) <u>Harf. Co., Maryland</u>  |                                       |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>  |                           | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |                                       |
| 13. FATHER'S NAME <u>John W. Chambers</u>   |                           | 14. MOTHER'S MAIDEN NAME <u>Alice Collins</u>   |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                           | 16. SOCIAL SECURITY NO. <u>None</u>   |                                       |
| 17. INFORMANT (Name) <u>Mrs. Frances L. Brown Severn</u>  |                           | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asthma</u><br>916.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) _____ (c) _____ |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)   |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                       |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned in home fire</u>   |                                       |
| 20c. TIME OF INJURY Month, Day, Year <u>7-12-61</u>   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>  |                           | 20f. (City or town) <u>Bel Air</u> (County) <u>Harford</u> (State) <u>Md.</u>   |                                       |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                           |   |                                       |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u>   |                           | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u>   |                                       |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer-M.D.</u>  |                           | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-12-61</u>  |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                           | 22b. DATE THEREOF <u>July 13, 1961</u>  |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Clarks Chapel Cem.</u>  |                           | 22d. LOCATION (City, town, or country) <u>Bel Air Rural, Harf. Co., Md.</u>   |                                       |
| 23. FUNERAL DIRECTOR <u>Joseph W. Foster</u>  |                           | 24a. REC'D BY REGISTRAR <u>W. Broadway &amp; Williams</u>   |                                       |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>  |                           | DATE <u>JUL 14 '61</u>  |                                       |

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08035

1  
FOR STATE  
HEALTH DEPT.

|  |                                  |   |   |  |   |   |   |
|--|----------------------------------|---|---|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Harford</b> MARYLAND   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> |   |   |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Havre de Grace</b>  |                                  | c. LENGTH OF STAY IN IB<br><b>4 hrs.</b>  |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Fallston r.d.</b>                                   |   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Harford Memorial Hospital</b>   |                                  |   |   | d. STREET ADDRESS<br><b>1</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>WILLIAM</b> Middle <b>POSEY</b> Last <b>CHOATE</b>   |                                  |   |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>10</b> Year <b>1961</b>   |   |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 25, 1908</b> |  | 9. AGE (In years last birthday)<br><b>53</b> yrs. | IF UNDER 1 YEAR<br>Months <b>53</b> Days <b>53</b>  | IF UNDER 24 HRS.<br>Hours <b>53</b> Min. <b>53</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Agriculture</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Sparta, N. C.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Robert L. Choate</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Vena Taylor</b>   |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>217-36-4912</b>   |   | 17. INFORMANT (Wife)<br><b>Mrs. Hazel L. Choate</b>  |   | Address<br><b>Fallston, R.D., Md.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease.</b><br>428-0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Multiple Traumatic Injuries.</b> |                                  |   |   |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Run over by tractor.</b>                                 |   |  |   |   |   |
| 20c. TIME OF INJURY<br>Hour a.m. <b>9:20</b> <del>xxx</del> Month, Day, Year <b>7/10 '61</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Farm</b>  |   | 20f. (City or town) (County) (State)<br><b>Fallston Harford Md.</b>                               |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |                                  |   |   |  |   |   |   |
| ACTUAL SIGNATURE<br><b>Charles S. Petty</b>  |                                  | M.D.<br><b>Charles S. Petty, M.D.</b>   |   | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |   | DATE SIGNED<br><b>7/11/61</b>   |   |
| EXAMINER'S NAME (Type)<br><b>Charles S. Petty, M.D.</b>  |                                  | Address (Street, city, town, or county)<br><b>Bel Air, Harf. Co., Md.</b>   |   |  |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>July 14, 1961</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Bel Air Memorial Gardens</b>  |   | 22d. LOCATION (City, town, or country) (State)<br><b>Bel Air, Harf. Co., Md.</b>                  |   |
| 23. FUNERAL DIRECTOR<br><b>Foster Funeral Home</b>   |                                  | ADDRESS<br><b>-W. Broadway &amp; Williams</b>   |   | 24a. REC'D BY REGISTRAR<br><b>JUL 13 '61</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Haines</b>   |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

100-7111  
100-7111

Harvard

Harvard

Harvard

Harvard

Harvard

Harvard

Harvard

WILLIAM

JOHN

CHAS.

JOHN

JOHN

Male

White

March 22, 1908

Robert L. Gordon

John Taylor

1-10-11

Robert L. Gordon

Multiple traumatic injuries

Run over by tractor

1:30 AM 1910

Harvard

Harvard

Robert L. Gordon

March 22, 1908

Robert L. Gordon

Harvard

Harvard

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

8044

08036

|   |                                  |   |  |  |  |  |   |
|---|----------------------------------|---|--|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Harford</u> |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Harrods-Grace</u>  |                                  | c. LENGTH OF STAY IN 1b<br><u>9 days</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Aberdeen</u>                                  |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Harford Memorial Hospital</u>  |                                  |   |  | d. STREET ADDRESS<br><u>Paradise Rd. Rt. # 2</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Ora</u> Middle <u>Lee</u> Last <u>Davis</u>   |                                  |   |  | 4. DATE OF DEATH<br>Month <u>7</u> Day <u>12</u> Year <u>1961</u>  |  |  |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Nov. 6, 1918</u>  |  | 9. AGE (In years lost birthday)<br><u>42</u> yrs.                                      | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Machine Operator</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Shoe</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>North Carolina</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.,</u>   |   |
| 13. FATHER'S NAME<br><u>Winfield Testerman</u>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Ollie Blevins</u>   |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>216-28-9175</u>   |  | 17. INFORMANT<br><u>John Lee Davis</u> Address <u>Aberdeen Md.,</u>  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>431X Pulmonary infarct</u><br>DUE TO (b) <u>Pulmonary embolism</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Fiedler's Myocarditis</u><br>DUE TO (c) <u>Friedler's Myocarditis</u> |                                  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>3 days</u>                     |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Pneumonia</u>  |                                  |   |  |  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/6/1961</u> to <u>7/12/1961</u> , that (I) (we) last saw the deceased alive on <u>7/12/1961</u> and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.   |                                  |   |  |  |  |  |   |
| 22a. SIGNATURE<br><u>Irvin Wachsmen</u> M.D.  |                                  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>      |  | 22b. DATE SIGNED   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Irvin Wachsmen</u>   |                                  |   |  | 22d. ADDRESS<br><u>407 S. Union Ave., Havre de Grace, Md.</u>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 23b. DATE THEREOF<br><u>7/16/1961</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Welcome Home Baptist</u>  |  | 23d. LOCATION (City, town, or county) (State)<br><u>Bel Air, R.D., Harford, Md.,</u>   |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Howard L. Brown</u>  |                                  |   |  | ADDRESS<br><u>Abingdon, Md.,</u>   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>JUL 18 '61</u>                                      |   |
|   |                                  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Hane</u>  |  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10036

CERTIFICATE OF DEATH

10036

(M)

Nov. 1940

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 8045 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08037

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Harford</b> <span style="float: right;">MARYLAND</span>   |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>e. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Harford</b></span> |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Joppa</b>   |  | c. LENGTH OF STAY IN 1b<br><b>Joppa</b>   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Joppa</b>   |  | d. STREET ADDRESS<br><b>Box 484 Rural #2</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Box 484 Rural #2</b>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <b>DAVID B. FAULKNER</b>   |  |   |  | <b>4. DATE OF DEATH</b><br>Month <b>July</b> Day <b>12</b> Year <b>1961</b>  |  |   |  |
| <b>5. SEX</b><br><b>Male</b>   |  | <b>6. COLOR OR RACE</b><br><b>White</b>   |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                      |  | <b>8. DATE OF BIRTH</b><br><b>10/23/1911</b>  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Implement Salesman</b>  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>Farm</b>   |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Pennsylvania</b>  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>                                |  |
| <b>13. FATHER'S NAME</b><br><b>David Budd Faulkner Sr.</b>   |  |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Elizabeth Uiele</b>  |  |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <b>No</b>  |  | <b>16. SOCIAL SECURITY NO.</b><br><b>184-09-9857</b>  |  | <b>17. INFORMANT</b><br>Address <b>wife - Box 484 - Joppa, Rural #2, Md.</b>   |  |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary artery sclerosis with recent occlusion of one branch of left anterior descending artery</b><br>DUE TO <b>420.1</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>420.1</b> DUE TO <b>420.1</b>  |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |   |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>  |  | <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |  |
| <b>20c. TIME OF INJURY</b><br>Hour <b>a.m.</b> <b>p.m.</b> <b>19</b>   |  | <b>20d. INJURY OCCURRED</b><br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town) (County) (State)</b>   |  |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/> |  |   |  |  |  |   |  |
| <b>ACTUAL SIGNATURE</b><br><b>Russell S. Fisher, M.D.</b>  |  |   |  | <b>CHIEF MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>  |  | <b>DATE SIGNED</b><br><b>7/12/61</b>  |  |
| <b>EXAMINER'S NAME (Type)</b>  |  |   |  | <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>  |  | <b>Address (Street, city, town, or county)</b>                                      |  |
| <b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>Burial</b>  |  | <b>22b. DATE THEREOF</b><br><b>7/15/1961</b>  |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><b>Troy Cemetery</b>  |  | <b>22d. LOCATION (City, town, or country) (State)</b><br><b>Troy - Pennsylvania</b> |  |
| <b>23. FUNERAL DIRECTOR</b><br><b>John F. Darring - Aberdeen, Md.</b>  |  |   |  | <b>24a. REC'D BY REGISTRAR</b><br><b>JUL 21 '61</b>  |  | <b>24b. REGISTRAR'S SIGNATURE</b><br><b>Arthur S. Kenna</b>                         |  |

1903

3042 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11

Harford

Harford

Joseph

Joseph

For the year 1903

REGISTRATION NO. 12

John J. Harford

John J. Harford

John J. Harford

John J. Harford

Formerly of the State of New York with recent occupation of one of the State of New York

X

X

1903

Joseph J. Harford, M.D.

John J. Harford

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

8046

# CERTIFICATE OF DEATH

Reg. Dist. No.

08038

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rocks</u>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural White Hall</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Rocks Of Deer Creek Rest Home</u>  |                                  | d. STREET ADDRESS<br><u>Madonna Road</u>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>William Walter Gemmill</u>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><u>July 1, 1961</u>   |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Oct. 23, 1883</u> |
| 9. AGE (In years last birthday)<br><u>77</u> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Motorman</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Balto. Transit</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>William E. Gemmill</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Elizabeth A. Campbell</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>216-03-1223</u>   |  |
| 17. INFORMANT<br><u>Walter W. Gemmill</u>   |                                  | Address<br><u>White Hall, Md.</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><u>420.1</u><br>(b) <u>Hypertensive Arteriosclerotic Cardio-vascular Disease</u><br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Diabetes Mellitus</u> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Immed.</u><br><u>Years</u>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><u>No Injury</u>  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>No Injury</u>  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>None</u> <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>None</u>   |                                  | 20f. (City or town) (County) (State)<br><u>None</u>   |  |
| 21. I certify that I attended the deceased from <u>7/11</u> , 19 <u>59</u> , to <u>7/1</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>6/27</u> , 19 <u>61</u> , and that death occurred at <u>8:30AM</u> , from the causes and on the date stated above.   |                                  |   |  |
| ACTUAL SIGNATURE<br><u>James F. White Jr.</u>   |                                  | ADDRESS (Street, city or town, state)<br><u>Houcks Mill Road Jarrettsville, Maryland</u>  |  |
| DATE SIGNED<br><u>7/1/61</u>  |                                  |   |  |
| PHYSICIAN'S NAME (Type)<br><u>James F. White Jr. M.D.</u>   |                                  | <u>Jarrettsville, Maryland</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>7/4/1961</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Norrisville</u>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Norrisville Maryland</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Charles E. Kurtz</u>   |                                  | ADDRESS<br><u>Jarrettsville, Md.</u>  |  |
| 24a. REC'D BY REGISTRAR<br><u>JUL 5 '61</u>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>William S. K...</u>  |  |

1933

1933

CERTIFICATE OF DEATH

RECEIVED

M

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8047

## CERTIFICATE OF DEATH

Reg. Dist. No.

08039

|   |                           |  |                                     |
|---|---------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>md.</u> b. COUNTY <u>Harford</u>                    |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>   |                           | c. LENGTH OF STAY IN 1b <u>23 years</u>  |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>128 Alice Ann St.</u>   |                           | d. STREET ADDRESS <u>128 Alice Ann St.</u>   |                                     |
| 3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Gibson</u> Middle <u>-</u> Last <u>Gibson</u>   |                           | 4. DATE OF DEATH <u>July 14</u> Month <u>19</u> Day <u>1961</u> Year   |                                     |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>B</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10 Dec 1885</u> |
| 9. AGE (In years last birthday) <u>75</u> yrs.  |                           | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>   |                                     |
| 11. BIRTHPLACE (State or foreign country) <u>Thomas Run, Md.</u>  |                           | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |                                     |
| 13. FATHER'S NAME <u>Samuel Gibson</u>  |                           | 14. MOTHER'S MAIDEN NAME <u>Lizzie Banks</u>   |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)   |                           | 16. SOCIAL SECURITY NO. <u>220-14-2972</u>   |                                     |
| 17. INFORMANT <u>Mrs. Lucy Gibson, 128 Alice Ann St.</u>  |                           | Address  |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cirrhosis of Liver</u><br>581.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ |                           | INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |                           |  |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19 p. m.   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |                                     |
| 21. I certify that I attended the deceased from <u>June</u> , 19 <u>58</u> , to <u>July 14</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 12</u> , 19 <u>61</u> , and that death occurred at <u>7<sup>00</sup> A.M.</u> , from the causes and on the date stated above.             |                           |  |                                     |
| ACTUAL SIGNATURE <u>Charles Richardson</u>  |                           | ADDRESS (Street, city or town, state) <u>M.D. 126 S Main, Bel Air Md.</u>  |                                     |
| PHYSICIAN'S NAME (Type) <u>Charles Richardson</u>   |                           | DATE SIGNED <u>7/14/61</u>   |                                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                           | 22b. DATE THEREOF <u>July 17/61</u>  |                                     |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Clark's Chapel</u>  |                           | 22d. LOCATION (City, town, or county) (State) <u>Bel Air Rural Md</u>  |                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster</u>   |                           | ADDRESS <u>Bel Air Md</u>  |                                     |
| 24a. REC'D BY REGISTRAR <u>JUL 18 '61</u>   |                           | 24b. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>   |                                     |





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any page is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
5M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                  |   |   |   |   |   |   |   |  |
|--|--|----------------------------------|---|---|---|---|---|---|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                  |   |   |   |   |   |   |   |  |
| 8048 MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                                  |   |   |   |   |   |   |   |  |
| 08040  |  |                                  |   |   |   |   |   |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Harford</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Havre de Grace</b><br>c. LENGTH OF STAY IN 1b<br><b>1 hour</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Harford Memorial Hospital</b>  |  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Harford</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Darlington</b><br>d. STREET ADDRESS<br><b>Rural</b> |   |   |   |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>RUTH Malissa HALL</b>  |  |                                  |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>July 9 1961</b>  |   |   |   |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b> |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>7/23/1892</b>                              |   | 9. AGE (In years last birthday) 68 yrs.<br>IF UNDER 1 YEAR Months Days<br>IF UNDER 24 HRS. Hours Min. |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>      |   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  |
| 13. FATHER'S NAME<br><b>Graville Haga</b>  |  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Thursea Brewer</b>   |   |   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>  |  |                                  | 16. SOCIAL SECURITY NO.<br><b>220-32-2928</b>   |   |   | 17. INFORMANT<br>Address<br><b>Ralph Hall Haver De Grace, Md.</b> |   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br>4 10X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Mitral insufficiency</b><br>DUE TO (c) <b>Old mitral endocarditis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                  |   |   |   |   |   |   |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |                                  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)               |   |   |   |   |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour e.m. p.m.<br><b>19</b>   |  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                                  |   |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |                                  |   |   |   |   |   |   |   |  |
| ACTUAL SIGNATURE<br><b>Russell S. Fisher</b><br>EXAMINER'S NAME (Type)<br><b>Russell S. Fisher</b>   |  |                                  |   |   | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED<br><b>July 10, 1961</b>  |   |   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |                                  | 22b. DATE THEREOF<br><b>7/12/1961</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>West Nottingham Cem.</b>   |   | 22d. LOCATION (City, town, or country) (State)<br><b>Colorado Md.</b> |   |   |  |
| 23. FUNERAL DIRECTOR<br><b>Thomas E. McMillen</b><br>ADDRESS<br><b>Rising Sun, Md.</b>   |  |                                  |   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>JUL 12 '61</b><br>24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |   |   |   |   |  |

MEDICAL CERTIFICATION

14

Housewife

Graville Hagg

No

220-32-2028 Ralph Hall

Thurston Brewer

Virginia

Own Home

U.S.A.

Haver De Grace, Md.

Burial

7/12/1901

West Nottingham

Colora

Rising Sun, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8049  
CERTIFICATE OF DEATH  
08041

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>HARFORD</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MD</b> b. COUNTY <b>HARFORD</b>                     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RURAL - BELAIR</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>40 YRS</b>   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RURAL BELAIR X</b>   |                                  | d. STREET ADDRESS<br><b>R.D. #2</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>P.D. #2</b>  |                                  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARIAN</b> Middle <b>VIRGINIA</b> Last <b>HANWAY</b>  |                                  | 4. DATE OF DEATH<br>Month <b>JULY</b> Day <b>26</b> Year <b>1961</b>   |  |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>MAR. 25, 1874</b> |
| 9. AGE (In years last birthday)<br><b>87</b> yrs.   |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>MD.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>CORNELIUS COURTNEY</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>LAURA MATILDA MAXWELL</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>MISS HANNAH F. HANWAY BELAIR MD RD #2</b>  |  |
| 17. INFORMANT<br><b>MISS HANNAH F. HANWAY BELAIR MD RD #2</b>   |                                  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Cronary Thrombosis &amp; Mesenteric Thrombosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebrovascular Disease</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>1/2 hr</b><br><b>1/2 hr</b><br><b>12 yrs</b> |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June 1942</b> to <b>July 1961</b> , that (I) (we) last saw the deceased alive on <b>July 26, 1961</b> , and that death occurred at <b>12:30</b> M, from the causes and on the date stated above.   |                                  |  |  |
| 22a. SIGNATURE<br><b>[Signature]</b> M.D.   |                                  | 22b. DATE SIGNED<br><b>6/27/61</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>[Signature]</b>  |                                  | 22d. ADDRESS<br><b>MD</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 23b. DATE THEREOF<br><b>JULY 29, 1961</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>CALVERY METH. CH. YD. HARFORD CO.</b>  |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>MD</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>R. Madison Mitchell</b>  |                                  | 25a. REG. BY REGISTRAR<br><b>APR 1 61</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Evans</b>  |                                  | 25c. ADDRESS<br><b>MD</b>  |  |

2042

(M)

(1)

TO: THE ADJUTANT GENERAL  
FROM: THE CHIEF OF STAFF  
SUBJECT: [Illegible]  
[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page. It appears to be a memorandum or report.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

8050

08042

|   |                           |   |                                   |
|---|---------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>    |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>   |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>  |                                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>   |                           | d. STREET ADDRESS <u>112 Fenway St</u>  |                                   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           |   |                                   |
| 3. NAME OF DECEASED (Type or print) First <u>Calvin</u> Middle <u>L.</u> Last <u>Harlin</u>   |                           | 4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1961</u>  |                                   |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/25/1914</u> |
| 9. AGE (In years last birthday) <u>47</u> yrs.  |                           | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.   |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic/Driver</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>   |                                   |
| 11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>  |                           | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |                                   |
| 13. FATHER'S NAME <u>(unknown) Harlin</u>   |                           | 14. MOTHER'S MAIDEN NAME <u>Ausie Phumley</u>   |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>II</u>  |                           | 16. SOCIAL SECURITY NO. <u>218-05-5130</u>  |                                   |
| 17. INFORMANT <u>wife - 952 Roache St. Indianapolis - Ind.</u>  |                           | Address   |                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |                           | INTERVAL BETWEEN ONSET AND DEATH  |                                   |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br><u>420.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Thrombophlebitis</u><br>DUE TO<br>(c) <u>Arteriosclerotic Heart Disease</u> |                           |   |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(a) Congestive Heart Failure &amp; Pneumonitis</u> (b) <u>Gastroduodenitis &amp; Pyloric Spasms</u>  |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)  |                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6/8</u> 19 <u>61</u> , to <u>7/7</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7/7</u> 19 <u>61</u> , and that death occurred at <u>1:35</u> P.M. from the causes and on the date stated above.       |                           |   |                                   |
| 22a. SIGNATURE <u>George T. Stansbury</u> M.D.  |                           | 22b. DATE SIGNED <u>7/8/61</u>  |                                   |
| 22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>   |                           | 22d. ADDRESS <u>569 Revolution St., Haver de Grace, Md.</u>   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                           | 23b. DATE THEREOF <u>7/10/1961</u>  |                                   |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Wt. Pabery Cemetery</u>   |                           | 23d. LOCATION (City, town, or county) (State) <u>Aberdeen, Maryland</u>   |                                   |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarrington - Aberdeen, Maryland</u>   |                           | 25. REC'D BY REGISTRAR <u>Arthur L. Kraus</u>   |                                   |
| 25a. DATE <u>JUL 12 '61</u>   |                           | 25b. REGISTRAR'S SIGNATURE  |                                   |

1004

CERTIFICATE OF DEATH

1004

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. The text appears to be a medical or legal record.]*



# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
5M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                           |                    |  |  |   |  |  |                   |  |  |  |  |  |  |
|---|--|---------------------------|--------------------|--|--|---|--|--|-------------------|--|--|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                           |                    |  |  |   |  |  |                   |  |  |  |  |  |  |
| 8051 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                           |                    |  |  |   |  |  |                   |  |  |  |  |  |  |
| 08043   |  |                           |                    |  |  |   |  |  |                   |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND  |  |                           |                    |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>Harford</u> |  |  |                   |  |  |  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford</u>   |  |                           |                    |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Whiteford - RURAL</u>                             |  |  |                   |  |  |  |  |  |  |
| c. LENGTH OF STAY IN lb <u>1 day</u>  |  |                           |                    |  |  | d. STREET ADDRESS <u>Whiteford</u>  |  |  |                   |  |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>   |  |                           |                    |  |  |   |  |  |                   |  |  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)  |  |                           | First <u>ANNIE</u> |  |  | Middle <u>E.</u>  |  |  | Last <u>HENRY</u> |  |  | 4. DATE OF DEATH<br>Month <u>JULY</u> Day <u>11</u> Year <u>1961</u> |  |  |  |
| 5. SEX <u>F</u>   |  | 6. COLOR OR RACE <u>W</u> |                    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH. <u>DEC. 30, 1885</u>  |  | 9. AGE (In years last birthday) <u>75</u> yrs.                             |                   | IF UNDER 1 YEAR<br>Months <u>7</u> Days <u>11</u>                                    |  | IF UNDER 24 HRS.<br>Hours <u>11</u> Min. <u>61</u>                   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>  |  |                           |                    | 10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>   |  |   |  | 11. BIRTHPLACE (State or foreign country) <u>DARLINGTON, MD.</u>           |                   |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                              |  |  |  |
| 13. FATHER'S NAME <u>JOHN ORR</u>   |  |                           |                    |  |  | 14. MOTHER'S MAIDEN NAME <u>SUSIE LITTLE</u>  |  |  |                   |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |  |                           |                    | 16. SOCIAL SECURITY NO. <u>----</u>  |  | 17. INFORMANT <u>ARTHUR HENRY</u>   |  |  |                   | Address <u>WHITEFORD, MD.</u>  |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Fracture femur</u><br><u>904.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>-----</u><br>(a), stating the underlying cause last. } DUE TO<br>(c) <u>-----</u>  |  |                           |                    |  |  |   |  |  |                   |  |  | INTERVAL BETWEEN ONSET AND DEATH                                     |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>-----</u>   |  |                           |                    |  |  |   |  |  |                   |  |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |                           |                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in house</u>  |  |   |  |  |                   |  |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>7-9</u> p.m. <u>61</u>  |  |                           |                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RD</u>  |  | 20f. (City or town) <u>Whiteford</u> (County) <u>Har</u> (State) <u>MD</u> |                   |  |  |  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                           |                    |  |  |   |  |  |                   |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.  |  |                           |                    |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Beltin, MD.</u>  |  |  |                   | DATE SIGNED <u>7-11-61</u>   |  |  |  |  |  |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>   |  |                           |                    |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |  |                   |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  |                           |                    | 22b. DATE THEREOF <u>JULY 14, 1961</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>DARLINGTON</u>  |  |  |                   | 22d. LOCATION (City, town, or country) <u>DARLINGTON, MARYLAND</u> (State) <u>MD</u> |  |  |  |  |  |
| 23. FUNERAL DIRECTOR <u>John H. Harkins</u>   |  |                           |                    |  |  | ADDRESS <u>DELTA, PENNA.</u>  |  | 24a. REC'D BY REGISTRAR <u>Jul 13 '61</u>                                  |                   | 24b. REGISTRAR'S SIGNATURE <u>Charles L. Hines</u>                                   |  |  |  |  |  |

MEDICAL CERTIFICATION

FOR STATE  
FBI BUREAU

(M)

(I)

RECEIVED  
FBI BUREAU  
JAN 11 1961

WEST VIRGINIA STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: *John C. Jones*  
AGE: *45*  
SEX: *M*  
RACE: *W*  
DATE OF DEATH: *1-10-61*  
PLACE OF DEATH: *Home*  
CAUSE OF DEATH: *Heart Disease*  
MANNER OF DEATH: *Natural*  
SIGNATURE: *John C. Jones*  
DATE: *1-11-61*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
#

8052

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

08044

CERTIFICATE OF DEATH

|  |                               |  |                                    |
|--|-------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>HARFORD</b> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>HARFORD</b>               |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAYRE DE GRACE</b>   |                               | c. LENGTH OF STAY IN 1b <b>2 DAYS</b>  |                                    |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL HOSP.</b>   |                               | d. STREET ADDRESS <b>662 Green St</b>  |                                    |
| 3. NAME OF DECEASED (Type or print) <b>NORMAN</b> First <b>HOPKINS</b> Middle <b>HOPKINS</b> Last  |                               | 4. DATE OF DEATH <b>July 30</b> Month <b>19 61</b> Day Year  |                                    |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>MAY 7 1928</b> |
| 9. AGE (In years last birthday) <b>33</b> yrs.   |                               | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <b>RETIRED MAIL CARRIER</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov.</b>   |                                    |
| 11. BIRTHPLACE (State or foreign country) <b>MD</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |                                    |
| 13. FATHER'S NAME <b>GEORGE HOPKINS</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>ANNIE McCOMMONS</b>  |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>  |                               | 16. SOCIAL SECURITY NO. <b>—</b>   |                                    |
| 17. INFORMANT <b>DONALD F. STOOPES</b> Address <b>2615 JACKSON AVE CLAYMONT, DEL.</b>  |                               |  |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Myocardial Infarct</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic myocardiitis</b><br>(c) <b>—</b> |                               | INTERVAL BETWEEN ONSET AND DEATH   |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7-29-1961</b> to <b>7-30-1961</b> that (I) (we) lost <b>12:15</b> the deceased alive on <b>7-29-1961</b> , and that death occurred at <b>12:15</b> from the causes and on the date stated above.  |                               |  |                                    |
| 22a. SIGNATURE <b>[Signature]</b>  |                               | 22b. DATE SIGNED   |                                    |
| 22c. PHYSICIAN'S NAME (Type) <b>[Signature]</b>  |                               | 22d. ADDRESS   |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |                               | 23b. DATE THEREOF <b>8-1-1961</b>  |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY <b>ROCK RUN CEM.</b>  |                               | 23d. LOCATION (City, town, or county) (State) <b>HARFORD MD</b>  |                                    |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>R. Madison Mitchell</b> ADDRESS <b>HAYRE DE GRACE</b>  |                               | 25a. REC'D BY REGISTRAR <b>AUG 2 '61</b> DATE  |                                    |
|  |                               | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>   |                                    |

205410

5268

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8053

CERTIFICATE OF DEATH

08045

|   |  |   |   |   |   |   |  |  |
|---|--|---|---|---|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Harford</b> <b>MARYLAND</b>   |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>                  |   |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Aberdeen</b>   |  |   | c. LENGTH OF STAY IN 1b<br><b>5 hours</b>       |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Aberdeen</b> |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U. S. Army Hospital</b>  |  |   |   | d. STREET ADDRESS<br><b>19 Monroe</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>VALERIE</b> Middle <b>HUNTER</b> Last <b>HUNTER</b>   |  |   |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>25</b> Year <b>1961</b>  |   |   |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>Negroid</b>  |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>July 25, 1961</b>  |  |  |
| 9. AGE (In years last birthday) yrs.<br><b>4</b>  |  | IF UNDER 1 YEAR<br>Months <b>50</b>   |   | IF UNDER 24 HRS.<br>Hours <b>4</b> Min. <b>50</b>   |   |   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>N/A</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b> |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>             |  |
| 13. FATHER'S NAME<br><b>CAESAR HUNTER</b>   |  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>ERNESTINE G BROWN</b>  |   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>N/A</b>  |  | 16. SOCIAL SECURITY NO.<br><b>N/A</b>   |   | 17. INFORMANT<br>Address<br><b>Cesar Hunter (Father) Same as # 2</b>  |   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Immaturity (26-27 weeks gestation)</b><br><b>761.5</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Premature rupture of membranes (Spontaneous)</b><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |  |   |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>4hrs 50mins</b> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |  |
| 21. I certify that <b>MD</b> (this hospital) attended the deceased from <b>0135 July 25 1961</b> to <b>0625 July 25, 1961</b> , that <b>no</b> (we) last saw the deceased alive on <b>July 25, 1961</b> , and that death occurred at <b>0625 AM</b> from the causes and on the date stated above.   |  |   |   |   |   |   |  |  |
| 22a. SIGNATURE<br><b>Hans A. Keuls</b>  |  |   |   | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>July 25, 1961</b>   |   | 22b. DATE SIGNED  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>HANS A. KEULS</b>  |  |   |   | 22d. ADDRESS <b>U. S. Army Hospital<br/>Aberdeen Proving Ground, Maryland</b>   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>7/26/61</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven</b>   |   | 23d. LOCATION (City, town, or county) (State)<br><b>Aberdeen Prov. Gd., Md.</b>                   |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>John G. Tarring</b><br><b>Aberdeen, Md.</b>  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 27 '61</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Wm. S. Kenna</b>   |  |  |

John G. Tarring 2050395XV0

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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MAYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

|  |                           |   |                                     |
|--|---------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>HARFORD</b> <b>MARYLAND</b>  |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before 8 months)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>   |                                     |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAVRE DE GRACE</b>   |                           | c. LENGTH OF STAY IN 1b <b>14 DAYS</b>  |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HARFORD MEMORIAL HOSPITAL</b>  |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     |
| 3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE WINFIELD JAMES</b>   |                           | 4. DATE OF DEATH Month Year <b>JULY 10 1961</b>   |                                     |
| 5. SEX <b>M</b>  | 6. COLOR OR RACE <b>C</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>May 5, 1881</b> |
| 9. AGE (In years last birthday) <b>80 yrs.</b>   |                           | 10. IF UNDER 1 YEAR Months Days Hours Min. <b>2 3</b>   |                                     |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Caretaker</b>  |                           | 12. KIND OF BUSINESS OR INDUSTRY <b>Private Estate</b>  |                                     |
| 13. FATHER'S NAME <b>JAMES</b>   |                           | 14. MOTHER'S MAIDEN NAME <b>ELIZABETH HALL</b>  |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                           | 16. SOCIAL SECURITY NO. <b>217-14-1995A</b>   |                                     |
| 17. INFORMANT Address <b>Mrs. Genivie Jones - Darlington, Md.</b>  |                           | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Thromia</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>Paget's disease</b><br>(c) <b>Renal Insufficiency (Nephritis)</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>603X</b> |                                     |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                           | 20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                     |
| 21. TIME OF INJURY Hour e.m. p.m. <b>19</b>  |                           | 22. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                     |
| 23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 24. (City or town) (County) (State)   |                                     |
| 25. I certify that (I) (this hospital) attended the deceased from <b>June 24, 1961</b> to <b>July 10, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 10, 1961</b> , and that death occurred at <b>3:10 PM</b> , from the causes and on the date stated above. |                           |   |                                     |
| 26. SIGNATURE <b>George T. Stansbury</b> M.D.  |                           | 27. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |                                     |
| 28. PHYSICIAN'S NAME (Type) <b>George T. Stansbury</b>   |                           | 29. ADDRESS <b>509 Revolution St. Havre de Grace, Md.</b>   |                                     |
| 30. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                           | 31. DATE THEREOF <b>July 13, 1961</b>   |                                     |
| 32. NAME OF CEMETERY OR CREMATORY <b>Berkley Cemetery</b>  |                           | 33. LOCATION (City, town or county) (State) <b>Darlington, Maryland</b>   |                                     |
| 34. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur J. Bullock, Havre de Grace, Md.</b>   |                           | 35. ADDRESS <b>550 Lenox St.</b>  |                                     |
| 36. REC'D BY REGISTRAR <b>DATE JUL 13 '61</b>  |                           | 37. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>  |                                     |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Hartford</u> <b>MARYLAND</b>  |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>HARTFORD</u>                       |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Jarrettsville</u>   |  | c. LENGTH OF STAY IN 1b<br><u>15 MIN.</u>   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Rural BALDWIN</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Office Dr White</u>   |  |   |  | d. STREET ADDRESS<br><u>Route 1, Box 341</u>   |  |   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) First Middle Last<br><u>Celia EMELINE JONES</u>  |  |   |  | <b>4. DATE OF DEATH</b> Month Day Year<br><u>July 25 1961</u>  |  |   |  |
| <b>5. SEX</b><br><u>F</u>  |  | <b>6. COLOR OR RACE</b><br><u>W</u>   |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><u>OCT. 18, 1910</u>   |  |
| <b>9. AGE</b> (In years, last birthday)<br><u>50</u> yrs.  |  | <b>IF UNDER 1 YEAR</b><br>Months Days Hours Min.  |  | <b>IF UNDER 24 HRS.</b><br>Months Days Hours Min.  |  |   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  |   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Home</u>  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>LANSING, N.C.</u>                |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>   |  |   |  |  |  |   |  |
| <b>13. FATHER'S NAME</b><br><u>GEORGE STIKE</u>  |  |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>AMANDA HAM</u>   |  |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>  |  |   |  | <b>16. SOCIAL SECURITY NO.</b><br><u>LILLARD M. JONES</u>  |  | <b>17. INFORMANT</b> Address <u>Route 1, Box 341</u><br><u>BALDWIN, MD</u>                        |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b)<br>(c) |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  |  |   |  |  |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| <b>20c. TIME OF INJURY</b> Hour e.m. p.m. <u>19</u>  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town) (County) (State)</b>   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from <u>1-1</u>....., 19<u>57</u>, to <u>7-25</u>....., 19<u>61</u>, that (I) (we) last saw the deceased alive on <u>1-20</u>.....19<u>61</u> and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.</b>  |  |   |  |  |  |   |  |
| <b>22a. SIGNATURE</b><br><u>Gerald C Palmer</u>  |  |   |  | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>               |  | <b>22b. DATE SIGNED</b><br><u>7-26-61</u>   |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><u>Gerald C Palmer MD</u>   |  |   |  | <b>22d. ADDRESS</b><br><u>Bel Air, Md</u>  |  |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>BURIAL</u>  |  | <b>23b. DATE THEREOF</b><br><u>7/28/1961</u>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Eldredth</u>   |  | <b>23d. LOCATION (City, town or county) (State)</b><br><u>Lansing N.C.</u>                        |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Charles E. Rutz</u>  |  |   |  | <b>ADDRESS</b><br><u>Jarrettsville, Md</u>   |  | <b>25e. REC'D BY REGISTRAR</b><br><u>JUL 28 '61</u>   |  |
|  |  |   |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Arthur S. Kraus</u>  |  |   |  |

(M)

(1)

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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

08048

|   |  |   |  |   |  |   |  |   |  |   |  |  |  |   |  |  |  |  |  |
|---|--|---|--|---|--|---|--|---|--|---|--|--|--|---|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Hartford</u> <b>MARYLAND</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u><br>c. LENGTH OF STAY IN 1b <u>10 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hartford Memorial Hospital</u>   |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Hartford</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u><br>d. STREET ADDRESS <u>504 Fountain Green Rd</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |   |  |   |  |  |  |   |  |  |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Mary Hale Kuykendall</u>   |  | <b>4. DATE OF DEATH</b><br>Month <u>July</u> Day <u>22</u> Year <u>1961</u> |  | <b>5. SEX</b><br><u>Female</u>  |  | <b>6. COLOR OR RACE</b><br><u>White</u> |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><u>Apr. 13, 1884</u> |  | <b>9. AGE</b> (In years last birthday) <u>77</u> yrs.  |  | <b>IF UNDER 1 YEAR</b><br>Months <u>  </u> Days <u>  </u> |  | <b>IF UNDER 24 HRS.</b><br>Hours <u>  </u> Min. <u>  </u>                  |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>  |  |   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Gift Shop</u>   |  |   |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>West Virginia</u>   |  |   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>  |  |   |  |  |  |  |  |
| <b>13. FATHER'S NAME</b> <u>Samuel McNeill</u>  |  |   |  | <b>14. MOTHER'S MAIDEN NAME</b> <u>Amanda McPherson Aruckle McNeill</u>   |  |   |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>   |  |   |  | <b>16. SOCIAL SECURITY NO.</b> <u>  </u>   |  |   |  | <b>17. INFORMANT</b> <u>Robert S. Kuykendall</u> <u>Bel Air, R.D., Md.</u> |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (1) <u>Terminal pneumonia, bilateral</u><br><u>492 X</u><br>DUE TO (2) <u>Hemiplegia, right</u><br>DUE TO (3) <u>Hypertensive and arteriosclerotic Cardio-vascular Disease</u><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Diabetes mellitus</u> |  |   |  |   |  |   |  |   |  |   |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>6 days</u><br><u>11 days</u><br><u>1 year</u>                  |  |   |  |  |  |  |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE</b> (CONDITION GIVEN IN PART I (a)) <u>  </u>  |  |   |  |   |  |   |  |   |  |   |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |  |   |  |  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |  |   |  |   |  |   |  |   |  |   |  | <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u> |  |   |  |  |  |  |  |
| <b>20c. TIME OF INJURY</b><br>Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>   |  |   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>   |  |   |  | <b>20f. (City or town)</b> <u>  </u> <b>(County)</b> <u>  </u> <b>(State)</b> <u>  </u>                      |  |   |  |  |  |  |  |
| <b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>7/12</u> 19 <u>61</u> to <u>7/22</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>July 22</u> 19 <u>61</u> , and that death occurred at <u>9:50</u> AM, from the causes and on the date stated above.   |  |   |  |   |  |   |  |   |  |   |  |  |  |   |  |  |  |  |  |
| <b>22a. SIGNATURE</b> <u>Edward C. Loo</u>  |  |   |  |   |  |   |  |   |  |   |  | <b>22b. DATE SIGNED</b> <u>7/22/61</u>   |  |   |  |  |  |  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Edward C. Loo, M.D.</u>  |  |   |  |   |  |   |  |   |  |   |  | <b>22d. ADDRESS</b> <u>Havre de Grace, Md.</u>   |  |   |  |  |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>   |  |   |  | <b>23b. DATE THEREOF</b> <u>July 22, 1961</u>   |  |   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Thrush F.H.,</u>   |  |   |  | <b>23d. LOCATION</b> (City, town or county) <u>Moorefield</u> <b>(State)</b> <u>W.Va.,</u>                   |  |   |  |  |  |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Howard A. McComas &amp; Son</u>  |  |   |  |   |  |   |  |   |  |   |  | <b>25a. REC'D BY REGISTRAR</b> <u>Abingdon, Md.,</u>   |  |   |  | <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>                   |  |  |  |

17

Apr. 13, 1884

17

Gilt Shop

Robert B. Wyndham

Robert B. Wyndham, Baltimore, Md.

no

Robert B. Wyndham, Baltimore, Md.  
July 2, 1884  
Thames F. H.

Robert B. Wyndham

N. Y.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

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|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u><br>c. LENGTH OF STAY in 1b <u>1 day</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial</u>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Md</u><br>b. COUNTY <u>Cecil</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville Rural</u><br>d. STREET ADDRESS <u>Frenchtown Rd.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Mattie</u> Middle <u>V.</u> Last <u>Linton</u>  |   | 4. DATE OF DEATH<br>Month <u>7</u> Day <u>18</u> Year <u>1961</u>  |   |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><u>11-5-1898</u>  |
| 9. AGE (In years last birthday) <u>62</u> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u>   | 11. IF UNDER 24 HRS.<br>Hours <u>0</u> Min. <u>0</u>                        |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>House Wife</u>  |   |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Md</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   |
| 13. FATHER'S NAME <u>Unknown</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>   |   | 16. SOCIAL SECURITY NO. <u>Unknown</u>   |   |
| 17. INFORMANT Address <u>Mrs Clifford Brogan, Havre De Grace Md.</u>  |   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>(1) Sudden Aneurysm aortal idy</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u>id</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>id</u> |   | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Hour a.m. <u>19</u><br>p.m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/18</u> <u>1961</u> , to <u>7/18</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>7/18</u> <u>1961</u> , and that death occurred at <u>7:00</u> P.M. from the causes and on the date stated above.   |   |  |   |
| 22a. SIGNATURE <u>Irvin Wachsmann</u> M.D.  |   | 22b. DATE SIGNED <u>7/19/61</u>  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>Irvin Wachsmann</u>   |   | 22d. ADDRESS <u>Havre De Grace, Md.</u>  |   |
| 23a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>7-21-1961</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>  | 23d. LOCATION (City, town or county) (State) <u>Port Deposit, Md. rural</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee, a Patterson &amp; Son,</u>   |   | 25a. REC'D BY REGISTRAR <u>Perryville, Md</u>  |   |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. France</u>  |   | DATE <u>JUL 21 '61</u>   |   |

942

3052

M

1

FRANCIS TOWN, MD.

11-2-1888

House Wife

Unknown

Mrs. Clifford Rogers, Havre de Grace, Md.

7-21-1901 Agency Gen. Sec'y Fort Deposit, Md. (trial)

Ferryville, Md.

Havre de Grace, Md.

Irvin Workman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8058

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 2 & 14 Film G291 7/24/61 iwk  
CERTIFICATE OF DEATH

Reg. Dist. No. 08050

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Harford</u>                     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>   |                                  | c. LENGTH OF STAY IN 1b <u>1 mo</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Convalescing Home</u>   |                                  | d. STREET ADDRESS <u>428 Market St.</u>  |  |
| 3. NAME OF DECEASED (Type or print) <u>W</u> First <u>Scott</u> Middle <u>McKENNEY</u> Last <u>McKENNEY</u>   |                                  | 4. DATE OF DEATH <u>5 May</u> 19 <u>61</u> Month <u>5</u> Day <u>15</u> Year <u>1961</u>   |  |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u>        | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/2/1874</u>                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cultured</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Fisherman</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>North East Md.</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Scott McKenney</u>   |                                  | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Mahoney</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>   |                                  | 16. SOCIAL SECURITY NO. <u>Unknown</u>   |  |
| 17. INFORMANT <u>Mrs Paul D. Craig</u> Address <u>Bel Air, Md.</u>  |                                  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic CVD disease</u><br><u>422.01</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ |                                  | INTERVAL BETWEEN ONSET AND DEATH _____   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   |                                  | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>4-21</u> , 19 <u>61</u> , to <u>7-15</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7-12</u> , 19 <u>61</u> , and that death occurred at <u>7 A</u> . M, from the causes and on the date stated above.  |                                  |  |  |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.  |                                  | ADDRESS (Street, city or town, state) <u>Bel Air, Md</u>   |  |
| PHYSICIAN'S NAME (Type) <u>Gerald C Palmer MD</u>   |                                  | DATE SIGNED <u>7-13-61</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   | 22b. DATE THEREOF <u>7/18/61</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Elin</u>   | 22d. LOCATION (City, town, or county) (State) <u>Harford County Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Rm</u> ADDRESS <u>Harford County</u>  |                                  | 24a. REC'D BY REGISTRAR <u>JUL 18 '61</u>  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>                      |

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1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8059 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08051

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>md.</u> b. COUNTY <u>Harford</u>                    |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hannedale</u>   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hannedale</u>  |   |
| c. LENGTH OF STAY IN 1b <u>10 yrs.</u>  |  | d. STREET ADDRESS <u>1736 Ostego St</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Susquehanna River</u>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>EIpert</u> <u>LS</u> <u>MOORE</u>  | 4. DATE OF DEATH<br>Month Day Year<br><u>July</u> <u>23</u> <u>1961</u>  |  |   |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>C</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>June 6, 1944</u>                               |
| 9. AGE (In years last birthday) <u>17</u> yrs.  | IF UNDER 1 YEAR<br>Months Days   | IF UNDER 24 HRS.<br>Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>  | 10b. KIND OF BUSINESS OR INDUSTRY <u>High School</u>   | 11. BIRTHPLACE (State or foreign country) <u>Beulah, Mississippi</u>   | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>                          |
| 13. FATHER'S NAME <u>Robert Moore</u>   | 14. MOTHER'S MAIDEN NAME <u>Classic Mae Wright</u>   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   | 16. SOCIAL SECURITY NO. <u>none</u>  | 17. INFORMANT<br>Address <u>736 Otway St. Harford, Md.</u><br><u>Mr. Classic Mae Moore</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia due to drowning</u><br>929.8 DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____  |  |  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Swimming in S. River near the Toll bridge</u>   |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><u>7-22</u> <u>1961</u><br>Hour <u>8</u> p.m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Susquehanna River Hannedale Harford Md.</u>                                    | 20f. (City or town) (County) (State)                                  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |
| ACTUAL SIGNATURE <u>Gerold C Palmer MD</u>  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> 7-23-61<br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>BeDA in, Md.</u><br>Address (Street, city, town, or county) |  |   |
| EXAMINER'S NAME (Type)  | DATE SIGNED  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>July 29, 1961</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>Berkley Cemetery</u>   | 22d. LOCATION (City, town, or country) (State) <u>Harford Co. Md.</u> |
| 23. FUNERAL DIRECTOR <u>Otis J. Bullock, Harford, Md.</u>   | 24a. REC'D BY REGISTRAR <u>Charles S. Kraus</u><br>24b. REGISTRAR'S SIGNATURE<br>DATE <u>JUL 26 '61</u>  |  |   |

MEDICAL CERTIFICATION

10052

10053

(M)

(I)

*[Faint, mostly illegible handwritten notes and sketches, possibly including a diagram of a structure with a central vertical element and horizontal branches.]*

*[Faint handwritten notes and sketches at the bottom of the page, including a small diagram of a structure with a central vertical element and horizontal branches.]*



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8060 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08052

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Hampard</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>3V01-4</u>                      |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>  |  |   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Willoughby Beach</u>  |  |   |  | d. STREET ADDRESS <u>1940 W. Fayette St</u>  |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Theodore R. Morris</u>   |  |   |  | 4. DATE OF DEATH <u>7-4-1961</u>   |  |   |  |
| 5. SEX <u>M</u>   |  | 6. COLOR OR RACE <u>C</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Aug. 1902</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 9. AGE (In years last birthday) <u>58</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>7</u> Days <u>4</u>                              |  |
| 11. BIRTHPLACE (State or foreign country) <u>King Williams Va.</u>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?   |  |   |  |
| 13. FATHER'S NAME <u>Benjamin Morris</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Bessie I</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  | 16. SOCIAL SECURITY NO. <u>29-32-5417</u>   |  | 17. INFORMANT <u>May Penny 1330 Scott St. Washington Md</u>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia</u><br><u>850X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Drowning</u><br>DUE TO (c)  |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell off boat</u>  |  |   |  |
| 20c. TIME OF INJURY<br>Hour <u>7</u> p.m. <u>7-4-61</u>   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bank River</u>   |  | 20f. (City or town) <u>Edgewood</u> (County) <u>Hampard</u> (State) <u>MD</u> |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>Be Aci</u> DATE SIGNED <u>7-4-61</u>  |  |   |  |
|   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  |
|   |  |   |  | Address (Street, city, town, or county) <u>7-4-61</u>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 22b. DATE THEREOF <u>7/8/1961</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Union Baptist Church Cem</u>   |  | 22d. LOCATION (City, town, or country) (State) <u>King Williams Va.</u>       |  |
| 23. FUNERAL DIRECTOR <u>Mr. Kate Williams</u>   |  |   |  | ADDRESS <u>Schroeder St</u>  |  | 24e. REC'D BY REGISTRAR <u>JUL 6 '61</u>                                      |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>  |  |   |  |

0303

0303

M

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

8061

08053

|   |                               |  |  |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>HARFORD</b> <b>MARYLAND</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAVER DE GRACE</b> <b>17 Hrs.</b><br>c. LENGTH OF STAY IN b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HARFORD MEMORIAL HOSP</b>   |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAVER DE GRACE</b><br>d. STREET ADDRESS <b>705 LAfayette</b><br>a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Otis G</b>  |                               | 4. DATE OF DEATH <b>Murphy July 13 1961</b>  |  |
| 5. SEX <b>MALE</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>Sept. 14, 1899</b> |
| 9. AGE (In years, last birthday) <b>61 yrs.</b>   |                               | 10. IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>   |  |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>  |                               | 11b. KIND OF BUSINESS OR INDUSTRY <b>Aberdeen Proving Gr.</b>  |  |
| 11c. BIRTHPLACE (County & State, or foreign country) <b>Charlestown, Md.</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>George Henry Murphy</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Harriet Virginia Dennison</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |                               | 16. SOCIAL SECURITY NO. <b>214-01-7953</b>   |  |
| 17. INFORMANT <b>Mrs. H.C. Donohoo</b>  |                               | Address <b>705 LaFayette St., Haver de Gra</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Irreversible shock</b><br><b>541.9</b> DUE TO <b>Massive hemorrhage from duodenal ulcer</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>A.S.C.V.D., + Coronary disease @ Diabetes mellitus</b> |                               | INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b><br><b>2 yrs.</b>   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Dec 20th, 1960</b> to <b>July 13th, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 13th, 1961</b> , and that death occurred at <b>4:15 AM</b> , from the causes and on the date stated above.   |                               |  |  |
| 22a. SIGNATURE <b>Edward C. Loo, M.D.</b> M.D.  |                               | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Edward C. Loo, M.D.</b>   |                               | 22b. DATE SIGNED <b>7/13/61</b>  |  |
| 22d. ADDRESS <b>Haver de Grace, Md</b>  |                               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 23b. DATE THEREOF <b>7-16-1961</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Charlestown Methodist</b>   |                               | 23d. LOCATION (City, town or county) (State) <b>Charlestown, Cecil Co Md</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R Grant</b>  |                               | ADDRESS <b>North East Md</b>   |  |
| 25a. REC'D BY REGISTRAR <b>JUL 17 '61</b>   |                               | 25b. REGISTRAR'S SIGNATURE <b>Christina S. Kline</b>   |  |

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(1)

Handwritten text, possibly a list or index, with some words like "Handwritten" and "List" visible. Includes a circled '1' on the right.

Handwritten text, possibly a list or index, with some words like "Handwritten" and "List" visible. Includes a circled '1' on the right.

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Handwritten text, possibly a list or index, with some words like "Handwritten" and "List" visible. Includes a circled '1' on the right.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 08054

8062

|  |                                    |  |  |
|--|------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harper</u> MARYLAND  |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>md</u> b. COUNTY <u>Harper</u>                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bellaire</u>   |                                    | c. LENGTH OF STAY IN 1b <u>32</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bellaire</u>                       |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                                    | d. STREET ADDRESS <u>1064 Emmerton Road</u>  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                    |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>A</u> Middle <u>nn</u> Last <u>Owens</u>  |                                    | 4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1961</u>  |  |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u>          | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-13-79</u>                                     |
| 9. AGE (In years last birthday) <u>81</u> yrs.   |                                    | IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>B. &amp; O. Railroad Retired</u>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>  |  |
| 11. BIRTHPLACE (State or foreign country) <u>MD</u>  |                                    | 12. CITIZEN OF WHAT COUNTRY? <u>US</u>   |  |
| 13. FATHER'S NAME <u>Calvin Owens</u>  |                                    | 14. MOTHER'S MAIDEN NAME <u>Mary Jones</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)  |                                    | 16. SOCIAL SECURITY NO. <u>Wm Keith - 508 Forest Ave Catonsville</u>   |  |
| 17. INFORMANT <u>Wm Keith</u> Address <u>508 Forest Ave Catonsville</u>  |                                    |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic C V disease</u><br><u>422.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> |                                    | INTERVAL BETWEEN ONSET AND DEATH <u>✓</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>  |                                    | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>  |                                    | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                    | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>6-1</u> , 19 <u>61</u> , to <u>7-20</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7-1</u> , 19 <u>61</u> , and that death occurred at <u>MD</u> , from the causes and on the date stated above.   |                                    |  |  |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.   |                                    | ADDRESS (Street, city or town, state) <u>Bellaire, MD</u> DATE SIGNED <u>7-20-61</u>   |  |
| PHYSICIAN'S NAME (Type) <u>Gerald C Palmer MD</u>  |                                    |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 22b. DATE THEREOF <u>7-24-1961</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Swy Kief Cemetery</u>  | 22d. LOCATION (City, town, or county) (State) <u>Laurel Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Mar Nettleton - 3017 Federal Rd - 28</u> ADDRESS   |                                    | 24a. REC'D BY REGISTRAR DATE <u>JUL 26 '61</u>   |  |
|  |                                    | 24b. REGISTRAR'S SIGNATURE <u>Charles E. Huns</u>  |  |

CERTIFICATE OF DEATH

|                            |  |                          |  |                           |  |
|----------------------------|--|--------------------------|--|---------------------------|--|
| 1. Name of Deceased        |  | 2. Sex                   |  | 3. Age                    |  |
| 4. Date of Death           |  | 5. Time of Death         |  | 6. Place of Death         |  |
| 7. Cause of Death          |  | 8. Manner of Death       |  | 9. Signature of Physician |  |
| 10. Signature of Registrar |  | 11. Date of Registration |  | 12. Office of Registrar   |  |

JAM BRID

THE STATE OF MASSACHUSETTS, COUNTY OF SUFFOLK, ss. I, the undersigned, Registrar of the County of Suffolk, do hereby certify that the foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears in the records of the County of Suffolk, and that the same is a true and correct copy of the original record of the death of the person named therein, as the same appears in the records of the County of Suffolk.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
SM 9/60

1  
FOR STATE  
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                               |  |   |  |  |  |   |  |   |  |
|---|--|-------------------------------|--|---|--|--|--|---|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                               |  |   |  |  |  |   |  |   |  |
| 8063 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                               |  |   |  |  |  |   |  |   |  |
| 08055   |  |                               |  |   |  |  |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND  |  |                               |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Harford</u> |  |   |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Bel Air</u>  |  |                               |  | c. LENGTH OF STAY in 1b   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Bel Air</u>                                   |  |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>RDI</u>  |  |                               |  |   |  | d. STREET ADDRESS<br><u>RDI</u>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><u>NATHANIEL PINKNEY</u>   |  |                               |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><u>July 3 1961</u>   |  |   |  |   |  |
| 5. SEX<br><u>M</u>  |  | 6. COLOR OR RACE<br><u>C</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>April 15, 1970</u>  |  | 9. AGE (In years last birthday)<br><u>91</u> yrs.                                   |  | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min.                                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Farmer</u>  |  |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Owner</u>   |  |  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                        |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.,</u>  |  |
| 13. FATHER'S NAME<br><u>William Pinkney</u>   |  |                               |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Adeline Chambers</u>  |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give year or dates of service)<br><u>no</u>  |  |                               |  | 16. SOCIAL SECURITY NO.<br><u>none</u>  |  | 17. INFORMANT<br>Address<br><u>Sylvester Pinkney Bel Air R.D., Md.,</u>  |  |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u><br><u>422.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(e), stating the underlying cause last. } DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |                               |  |   |  |  |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                               |  |   |  |  |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Hour e.m. p.m.<br><u>19</u>  |  | Month, Day, Year<br><u>19</u> |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Bohigund 7-3-61</u><br>Address (Street, city, town, or county)<br>DATE JUL 6 '61 |  |                               |  |   |  |  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  |                               |  | 22b. DATE THEREOF<br><u>July 6, 1961</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Asbury</u><br>Address<br><u>Abingdon, Md.,</u>  |  | 22d. LOCATION (City, town, or country) (State)<br><u>Churchville, Harford, Md.,</u> |  |   |  |
| 23. FUNERAL DIRECTOR<br><u>Howard K. Palmer</u>   |  |                               |  | 24a. REC'D BY REGISTRAR<br>DATE JUL 6 '61   |  |  |  |   |  |   |  |
|   |  |                               |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kram</u>   |  |  |  |   |  |   |  |

(M)

(I)

Partner

Owner

Maryland

U.S.A.

Adeline Gromova

William Gromova

341 All R.D., No. 1  
Blyssway Parkway

NO

None

Chilmark, Massachusetts

Adrian

July 1, 1951

Bristol

Adrian, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

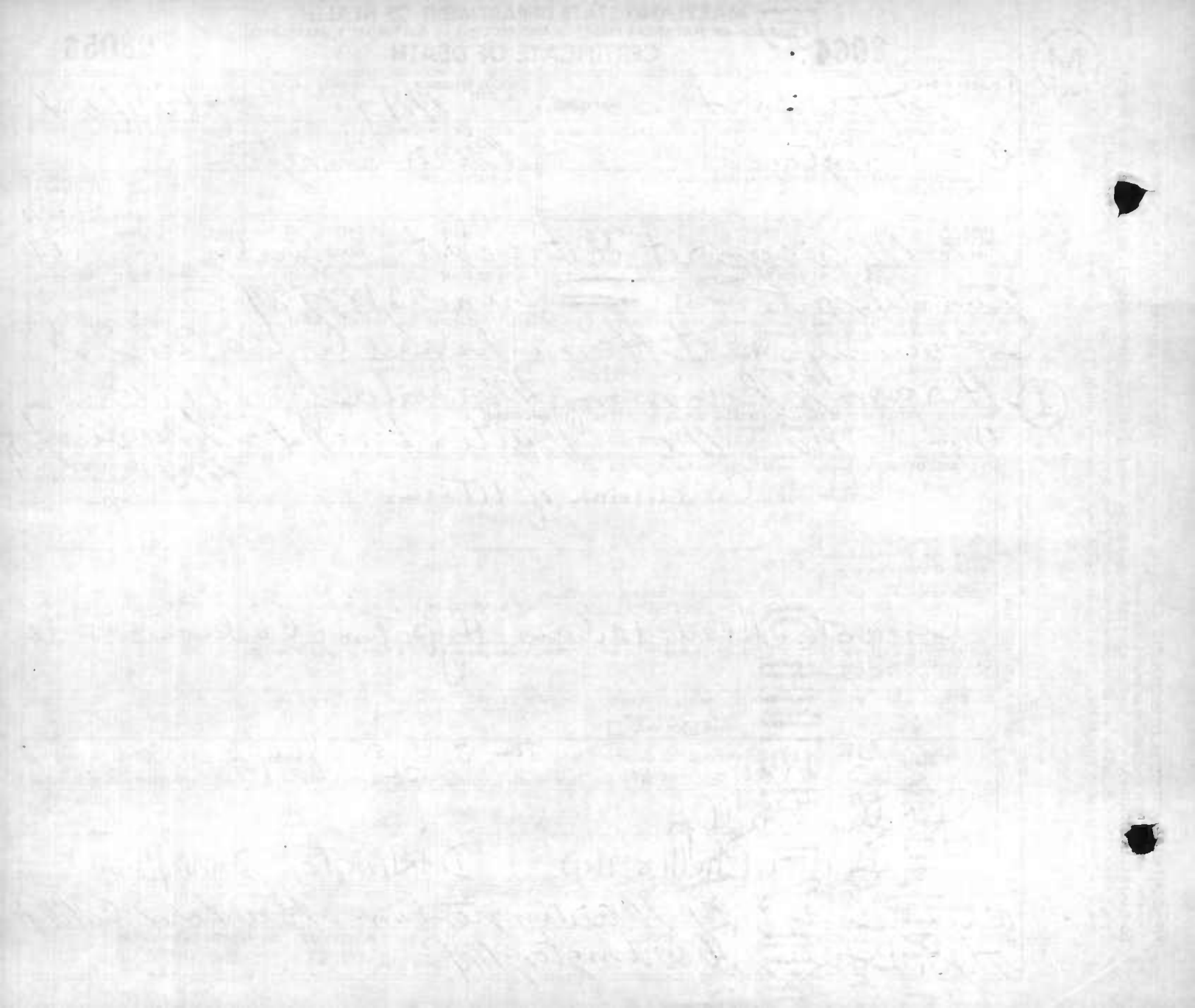
VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

8064

08056

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Harford</u>                                       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |  | d. STREET ADDRESS  |  |
| 3. NAME OF DECEASED (Type or print) <u>Margaret E. Pucket</u>   |  | 4. DATE OF DEATH <u>July 6</u> 19 <u>61</u>  |  |
| 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 22, 1877</u>  |  | 9. AGE (In years, last birthday) <u>84</u> yrs. 10. UNDER 1 YEAR <input type="checkbox"/> 11. UNDER 24 HRS. <input type="checkbox"/>                                       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework at home</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Russell Co., Va.</u>  |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  | 13. FATHER'S NAME <u>Hiram E. Robinson</u>   |  |
| 14. MOTHER'S MAIDEN NAME <u>Mahala Griffith</u>   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>No</u> 17. INFORMANT <u>Walter Pucket</u> Address <u>Darlington</u> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE: <u>Carcinoma of Uterus</u><br>DUE TO <u>174X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>174X</u> DUE TO (c) |  | INTERVAL BETWEEN ONSET AND DEATH <u>14y</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure - Hypertensive Cerebral</u>   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19 <u>61</u>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 3</u> 19 <u>55</u> to <u>July 6</u> 19 <u>61</u> , that (I) (we) lost the deceased on <u>July 2</u> 19 <u>61</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.                          |  |  |  |
| 22a. SIGNATURE <u>Dudley Phillips</u>   |  | 22b. DATE SIGNED   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>  |  | 22d. ADDRESS <u>Darlington, Maryland</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried July 8, 1961</u>  |  | 23b. DATE THEREOF  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Darlington Am</u>   |  | 23d. LOCATION (City, town, or county) (State) <u>Harford Co Md</u>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailes</u>  |  | 25a. REC'D BY REGISTRAR <u>Jul 12 '61</u>  |  |
| ADDRESS <u>Darlington, Md</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>  |  |



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8065

## CERTIFICATE OF DEATH

08058

|   |                                  |   |  |  |  |
|---|----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Harford</i> MARYLAND  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i> |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><i>Harre de Grace, Md</i>   |                                  |   | c. LENGTH OF STAY IN 1b<br><i>Lifetime</i>   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><i>Harford Memorial Hospital</i>  |                                  |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><i>Harre de Grace 24</i>                               |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   | d. STREET ADDRESS<br><i>562 Girard Street</i>  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Lewis</i> Middle <i>Edward</i> Last <i>Richardson</i>   |                                  |   | 4. DATE OF DEATH<br>Month <i>July</i> Day <i>7</i> Year <i>1961</i>  |  |  |
| 5. SEX<br><i>Male</i>   | 6. COLOR OR RACE<br><i>Negro</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>April 18, 1901</i>  | 9. AGE (In years last birthday)<br><i>60 yrs.</i>                      | IF UNDER 1 YEAR<br>Months <i>2</i> Days <i>19</i>                                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Baggage man</i>   |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>P.R.R. Ches. Adv.</i>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><i>Harre de Grace, Md</i> |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |                                  |   | 13. FATHER'S NAME<br><i>Floyd Richardson</i>   |  |  |
| 14. MOTHER'S MAIDEN NAME<br><i>Harriett Keithy</i>  |                                  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or 'unknown') (If yes give war/dates of service)<br><i>No</i>                        |  |  |
| 16. SOCIAL SECURITY NO.<br><i>716-01-7721</i>   |                                  |   | 17. INFORMANT<br><i>Mrs Virginia Richardson</i> Address <i>562 Girard Street Harre de Grace, Md</i>  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Intestinal Obstruction</i><br><i>153.2</i> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)<br>(c) <i>Carcinoma of the Sigmoid</i> |                                  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>(a) <i>Coronary Insufficiency</i><br>(2) <i>Hypertensive Cardiovascular disease (3) Emphysema</i>  |                                  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |                                  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <i>19</i>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town)   |                                  | (County)  |  | (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>7/5</i> , 19 <i>61</i> to <i>7/7</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>7/7</i> , 19 <i>61</i> , and that death occurred at <i>9:00</i> P.M., from the causes and on the date stated above.  |                                  |   |  |  |  |
| 22a. SIGNATURE<br><i>George T. Stansbury</i>  |                                  |   | 22b. DATE SIGNED<br><i>7/8/61</i>  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><i>George T. Stansbury</i>  |                                  |   | 22d. ADDRESS<br><i>569 Revolution St. Harre de Grace, Md.</i>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                                  | 23b. DATE THEREOF<br><i>7/11/61</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Berkley Cemetery</i>          |  |
| 23d. LOCATION (City, town or county)<br><i>Washington, Harford, Md</i>  |                                  | (State)   |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><i>Elmer E. Bullock</i>   |                                  |   | 25a. REC'D BY REGISTRAR<br><i>Jul 12 '61</i>   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Ciribon S. Kraw</i>  |                                  |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1008

(M)

Acute Intestinal Obstruction

Government of the Empire

Hygienic Cardiac and Respiratory Disease

1/2 1/2 1/2

1/2 1/2

George T. Stansbury  
George T. Stansbury

251 Kensington Avenue, New York



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Hartford</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Cecil</u>                       |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hartford-de-Gree</u>  |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>   |   |
| c. LENGTH OF STAY IN 1b <u>16 days</u>  |   | d. STREET ADDRESS <u>R.D.</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hartford Memorial Hospital</u>  |   | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| e. NAME OF DECEASED (Type or print) <u>David Franklin Rineer</u>  |   | 4. DATE OF DEATH <u>7 20 1961</u>  |   |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-28-1880</u>                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant</u>  | 9. AGE (In years last birthday) <u>80</u> yrs.                        |
| 11. BIRTHPLACE (County & State, or foreign country) <u>md</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   |
| 13. FATHER'S NAME <u>John F. Rineer</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Mary A. Archibald</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)  |   | 16. SOCIAL SECURITY NO. <u>214-34-3642</u>   |   |
| 17. INFORMANT <u>Edith M. Rineer</u>  |   | Address <u>Port Deposit, Md. Rural</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line, or (e), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (e) <u>Cerebral Hemorrhage</u><br>331X DUE TO <u>Arterio-Sclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Fracture - surgical neck right humerus</u> |   | INTERVAL BETWEEN ONSET AND DEATH <u>10 days 3 yrs</u>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Hour a.m. <u>19</u><br>p.m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 5, 1961</u> to <u>July 20, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 19, 1961</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.   |   |  |   |
| 22a. SIGNATURE <u>Clarence I. Benson</u> M.D.   |   | 22b. DATE SIGNED <u>7/21/61</u>  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>Clarence I. Benson</u>  |   | 22d. ADDRESS <u>Port Deposit, Md.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE THEREOF <u>7-24-1961</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cem.</u>   | 23d. LOCATION (City, town or county) (State) <u>Colora, Md. Rural</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson &amp; Son</u>  |   | 25a. REC'D BY REGISTRAR <u>Arthur L. Hanna</u>   |   |
| ADDRESS <u>Perryville, Md.</u>  |   | 25b. REGISTRAR'S SIGNATURE   |   |

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7-28-1980

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Lebanon

John T.

no

814-34-8843 Keith R. Binsell, Port Deposit, Md. Rural

Clarence I. Benson

Harriet 7-24-1981 West Nottingham Cms. Co., Md. Rural

John A. Binsell, Port Deposit, Md. Rural

# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                    |  |   |  |  |  |   |  |  |  |
|---|--|------------------------------------|--|---|--|--|--|---|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                    |  |   |  |  |  |   |  |  |  |
| 8067 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                                    |  |   |  |  |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> &3<br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u><br>c. LENGTH OF STAY in lb<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>  |  |                                    |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Harford</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> 28<br>d. STREET ADDRESS <u>Robbitt Road</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Diana First Middle Last</u><br><u>Phyllis Lee Ross</u>  |  |                                    |  |   |  | 4. DATE OF DEATH <u>July 7</u> 19 <u>61</u>  |  |   |  |  |  |
| 5. SEX <u>F</u>   |  | 6. COLOR OR RACE <u>W</u>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>1958</u><br><u>9-17-58</u>   |  | 9. AGE (in years last birthday) <u>2</u> yrs.                                 |  | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min.                               |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |                                    |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |  |  | 11. BIRTHPLACE (State or foreign country) <u>MD.</u>                          |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>DOMINICK ROSS</u>  |  |                                    |  |   |  | 14. MOTHER'S MAIDEN NAME <u>ROSE IRENE WEBB</u>  |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)  |  |                                    |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  |   |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Crushing injury chest</u><br>821X<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |                                    |  |   |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |                                    |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Motocycle fell over on her</u>                            |  |  |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Hour <u>am.</u> <u>7-7</u> 19 <u>61</u><br>p.m.  |  |                                    |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>   |  | 20f. (City or town) <u>Aberdeen</u> (County) <u>Harford</u> (State) <u>md</u> |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                    |  |   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <u>Dorald C Palmer</u>   |  |                                    |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>7-8-61</u>  |  |  |  | DATE SIGNED   |  |  |  |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>  |  |                                    |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Bel Air, md.</u>   |  |  |  | Address (Street, city, town, or county)                                       |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 22b. DATE THEREOF <u>7-10-1961</u> |  | 22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>   |  |  |  | 22d. LOCATION (City, town, or country) (State) <u>HARREDE GRACE, MD.</u>      |  |  |  |
| 23. FUNERAL DIRECTOR <u>R. Madison Mitchell</u>   |  |                                    |  | ADDRESS <u>Harre de Grace Md.</u>   |  | 24a. REC'D BY REGISTRAR <u>JUL 11 '61</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>                              |  |  |  |

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EXAMINEE'S SIGNATURE

(M)

2. SIGNATURE

(I)

## CERTIFICATE OF DEATH

Reg. Dist. No. 08061

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Harford</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural- Darlington</b>   |   | c. LENGTH OF STAY IN 1b<br><b>1 year</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Castleton Road</b>  |   | e. STREET ADDRESS<br><b>Castleton Road</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Cloyd</b> Middle <b>Albert</b> Last <b>Semones</b>   |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>28</b> Year <b>1961</b>  |   |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b>              | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 21, 1900</b>  |
| 9. AGE (In years lost birthday)<br><b>60</b> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Agriculture</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Pulaski, Virginia</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>James Semones</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Susan Childress</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>218-18-2889</b>   |   |
| 17. INFORMANT (Son)<br><b>J. Albert Semones</b>  |   | Address <b>Box 319 Forest Hill, Maryland</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the Liver</b><br>DUE TO <b>156.1</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>1 year</b><br>DUE TO (c) <b>1 year</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>NONE</b>   |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>19</b><br>p. m.   |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>August 17, 1960</b> to <b>July 28, 1961</b> , that I last saw the deceased alive on <b>July 26, 1961</b> , and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.   |   |   |   |
| ACTUAL SIGNATURE<br><b>Dudley Phillips M.D.</b>  |   | ADDRESS (Street, city or town, state)<br><b>Darlington Md</b>   |   |
| DATE SIGNED<br><b>7/28/61</b>  |   |   |   |
| PHYSICIAN'S NAME (Type)<br><b>Dudley Phillips, M.D.</b>  |   | <b>Darlington, Maryland</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>July 31, 1961</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Deer Creek Meth. Cem.</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Forest Hill (R.D.) Harf., Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph W. Foster</b>  |   | 24. REC'D BY REGISTRAR<br><b>Aug 1 '61</b>  |   |
| ADDRESS<br><b>W. Broadway &amp; Williams St. Bel Air, Maryland</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Harris</b>   |   |

Joseph W. Foster

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME  
5M 9/60

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8069 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08062

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Penn</u> b. COUNTY <u>Lancaster</u>   |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Hampden</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>L + + 2</u>   |   |
| d. STREET ADDRESS<br><u>23 1/2 Main St</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Robert</u> Middle <u>Singor</u> Last <u>-</u>   |   | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>27</u> Year <u>1961</u>   |   |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><u>4/9/1927</u>                                     |
| 9. AGE (In years, if UNDER 1 YEAR, if UNDER 24 HRS.<br>last birthday) <u>34</u> yrs. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>   |   | 10. BIRTHPLACE (State or foreign country)<br><u>Lebanon Co. Pa. U.S.A.</u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)<br><u>Self</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Unknown</u>  |   |
| 11. FATHER'S NAME<br><u>Ray Singer</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |
| 13. MOTHER'S MARRIAGE NAME<br><u>Ethel Bundige</u>  |   | 14. CITIZEN OF WHAT COUNTRY?<br><u>711 Oak St. Palmyra, Pa.</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>WW2</u>   |   | 16. SOCIAL SECURITY NO.<br><u>Unknown</u>  |   |
| 17. INFORMANT<br><u>Mrs. M. P. Singer</u>   |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia due to drowning</u><br>929.8 DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO<br>(b) <u></u><br>(c) <u></u> |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.<br><u>Drowned</u>  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Drowned</u>   |   |
| 20c. TIME OF INJURY<br>Hour <u>3</u> p.m. Month <u>7-26</u> Day <u>41</u> Year <u>19</u>  | 20d. INJURY OCCURRED:<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Susquehanna River</u>   | 20f. (City or town) (County) (State)<br><u>Hampden Co. Md.</u>          |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |   |
| ACTUAL SIGNATURE<br><u>Derald C Palmer</u>  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Best in rd</u>  |   |
| EXAMINER'S NAME (Type)<br><u>Gerald C Palmer</u>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED<br><u>7-27-61</u>  |   |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   | Address (Street, city, town, or county)<br><u>Palmyra, Penna</u>   |   |
| 22a. BURIAL CREMATION REMOVAL (Specify)<br><u>7/27/61</u>   | 22b. DATE THEREOF<br><u>7/27/61</u>   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Unknown</u>   | 22d. LOCATION (City, town, or country) (State)<br><u>Palmyra, Penna</u> |
| 23. FUNERAL DIRECTOR<br><u>Foranston R. Hande Thae. Md</u>  |   | 24a. REC'D BY REGISTRAR<br>JUL 31 '61  |   |
| ADDRESS<br><u>Foranston R. Hande Thae. Md</u>   |   | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Thae</u>  |   |

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Project", "2-20-11", and "George" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

8070

08063

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|--|---|---|---|
| <b>1. PLACE OF DEATH</b><br>e. COUNTY <b>Harford</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Bel Air</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission)<br>a. STATE <b>Md.</b><br>b. COUNTY <b>Harford</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Bel Air</b><br>d. STREET ADDRESS <b>R. D. #2</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <b>Sarah E Sliver</b>  |   | <b>4. DATE OF DEATH</b><br>Month <b>July</b> Day <b>22</b> Year <b>1961</b>   |   |
| <b>5. SEX</b><br><b>Female</b>   | <b>6. COLOR OR RACE</b><br><b>white</b> | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | <b>8. DATE OF BIRTH</b><br><b>Aug. 22, 1882</b> |
| <b>9. AGE</b> (In years last birthday) <b>78 yrs.</b>  |   | <b>10. IF UNDER 1 YEAR</b><br>Months Days Hours Min.  |   |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>  |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>  |   |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Pylesville, Md.</b>  |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>USA</b>   |   |
| <b>13. FATHER'S NAME</b><br><b>George H. Combs</b>   |   | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Mary Tarbert</b>  |   |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)  |   | <b>16. SOCIAL SECURITY NO.</b>  |   |
| <b>17. INFORMANT</b><br><b>Harry B. Sliver</b>   |   | <b>Address</b><br><b>Bel Air, R. D. Md.</b>   |   |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>170X</b> DUE TO <b>Carcinoma - breast</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH |   |   |   |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   |   |   |
| <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |
| <b>20c. TIME OF INJURY</b><br>Hour a.m. p.m. <b>19</b>   |   | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |   | <b>20f. (City or town)</b> (County) (State)   |   |
| <b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>July 21, 1961</b> to <b>July 22, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 22, 1961</b> , and that death occurred at <b>11 PM</b> , from the causes and on the date stated above.  |   |   |   |
| <b>22a. SIGNATURE</b><br><b>Gerald C. Palmer</b><br>M.D.   |   | <b>22b. DATE SIGNED</b><br><b>July 22, 1961</b>   |   |
| <b>22c. PHYSICIAN'S NAME</b> (Type) <b>Gerald C. Palmer</b>  |   | <b>22d. ADDRESS</b><br><b>Bel Air, Md.</b>  |   |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>   |   | <b>23b. DATE THEREOF</b><br><b>7-25-1961</b>  |   |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>Mt. Olivet cemetery</b>  |   | <b>23d. LOCATION</b> (City, town or county) (State)<br><b>Whiteford, Md.</b>  |   |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>John H. Harkins</b>  |   | <b>25a. REC'D BY REGISTRAR</b><br><b>DEL 26 '61</b>   |   |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Arthur L. Kline</b>  |   |   |   |

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 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH  
 08064

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>HARFORD</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>                     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>   |  | c. LENGTH OF STAY IN 1b <u>17 DAYS</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hosp.</u>   |  | d. STREET ADDRESS <u>PERRYMAN</u>  |   |
| 3. NAME OF DECEASED (Type or print) First <u>JACOB</u> Middle <u>H</u> Last <u>Smith</u>   |  | 4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1961</u>  |   |
| 5. SEX <u>MALE</u>   | 6. COLOR OR RACE <u>Colored</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>APRIL 15, 1881</u>  |
| 9. AGE (In years last birthday) <u>80</u> yrs.   |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Worker</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>MD</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME <u>Henry Smith</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Martha Jane Williams</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>  |  | 16. SOCIAL SECURITY NO. <u>218-05-4238</u>   |   |
| 17. INFORMANT <u>Mr. Wm. H. Holtz</u>  |  | Address <u>413 S. Stokes St. Harford Md.</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Uremia</u><br>442X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO (c) <u>Hypertensive Cardio-renal disease</u> |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 10, 1961</u> to <u>July 27, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 27, 1961</u> , and that death occurred at <u>10<sup>00</sup></u> M, from the causes and on the date stated above.  |  |  |   |
| 22a. SIGNATURE <u>George T. Stansbury</u>  |  | 22b. DATE SIGNED <u>7/27/61</u>  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>  |  | 22d. ADDRESS <u>529 Revolution St. Harford, Maryland</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>July 1961</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cem</u>  | 23d. LOCATION (City, town, or county) (State) <u>Aberdeen, Harford Co., Md.</u>     |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E. Bellock</u>   |  | 25a. REC'D BY REGISTRAR <u>DATE JUL 31 '61</u>   |   |
| ADDRESS <u>Harford, Md.</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>  |   |

CERTIFICATE OF DEATH

1903

(M)

1903

*[Faint, mostly illegible text, likely a form or record, possibly containing names and dates.]*

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8072

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film G290 7/11/61 iwk

Reg. Dist. No. 08065

FOR STATE  
HEALTH DEPT.

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>HARFORD</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JOPPA P.O.</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WILGUS ROAD</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JOPPA P.O.</u><br>d. STREET ADDRESS <u>WILGUS ROAD</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>WILLIAM HERBERT STAINES JR.</u>  |  | 4. DATE OF DEATH Month Day Year<br><u>JULY 1, 1961</u>   |   |
| 5. SEX<br><u>MALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>1918 JULY 15, 1919</u>                          |
| 9. AGE (In years last birthday) <u>42</u> yrs.   |  | IF UNDER 1 YEAR<br>Months Days   | IF UNDER 24 HRS.<br>Hours Min.                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>AUTO REPAIR</u>   | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>           |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  | 13. FATHER'S NAME <u>WILLIAM H. STAINES, SR.</u>   |   |
| 14. MOTHER'S MAIDEN NAME <u>CLARA SOMMERS</u>  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)  |   |
| 16. SOCIAL SECURITY NO. <u>218-05-4519</u>   |  | 17. INFORMANT Address <u>FAMILY RECORDS</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCLUSION</u><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u><br>(c), stating the underlying cause lost. DUE TO (c) <u>420.1</u>   |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN</u>                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |
| ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D.  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN M.D.</u>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  | DATE SIGNED <u>July 1, 1961</u>  |   |
| 22a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>  | 22b. DATE THEREOF <u>JUL 3, 1961</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMORIAL</u>  | 22d. LOCATION (City, town, or county) (State) <u>PARKVILLE, MD.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burro' Sme, Towson, Md.</u>   |  | ADDRESS  |   |
| 24a. REC'D BY REGISTRAR <u>JUL 5 '61</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>   |   |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE  
HEALTH DEPT.



TO BE FILLED BY THE MEDICAL EXAMINER  
IN THE CASE OF A DEATH  
WHICH IS NOT A NATURAL DEATH  
OR A DEATH WHICH IS NOT  
THE RESULT OF A DISEASE  
OR A DEATH WHICH IS NOT  
THE RESULT OF AN INJURY  
OR A DEATH WHICH IS NOT  
THE RESULT OF A SUICIDE  
OR A DEATH WHICH IS NOT  
THE RESULT OF A HOMICIDE  
OR A DEATH WHICH IS NOT  
THE RESULT OF A WAR  
OR A DEATH WHICH IS NOT  
THE RESULT OF A PLAGUE  
OR A DEATH WHICH IS NOT  
THE RESULT OF A PESTILENCE  
OR A DEATH WHICH IS NOT  
THE RESULT OF A FLOOD  
OR A DEATH WHICH IS NOT  
THE RESULT OF A DROUGHT  
OR A DEATH WHICH IS NOT  
THE RESULT OF A Famine  
OR A DEATH WHICH IS NOT  
THE RESULT OF A WAR  
OR A DEATH WHICH IS NOT  
THE RESULT OF A PLAGUE  
OR A DEATH WHICH IS NOT  
THE RESULT OF A PESTILENCE  
OR A DEATH WHICH IS NOT  
THE RESULT OF A FLOOD  
OR A DEATH WHICH IS NOT  
THE RESULT OF A DROUGHT  
OR A DEATH WHICH IS NOT  
THE RESULT OF A Famine

## CERTIFICATE OF DEATH

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|   |  |  |
|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Harford</b>  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>MD</b> | b. COUNTY<br><b>Cecil</b>  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Harre-de-Grace</b>   | c. LENGTH OF STAY IN 1b<br><b>30 days</b>  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Port Deposit</b>  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Harford Memorial Hospital</b>  | d. STREET ADDRESS<br><b>60 S. Main. ST.</b>  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |
| 5. NAME OF DECEASED<br>(Type or print)<br><b>Anna J. Stephenson</b>   | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>1</b> Year <b>1961</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>W</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH<br><b>March 16 - 1878</b>  | 9. AGE (In years last birthday)<br><b>83 yrs.</b>  | IF UNDER 1 YEAR<br>Months <b>83</b> Days <b>0</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Work</b>  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>MD</b>   |
| 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>   | 13. FATHER'S NAME<br><b>Jacohary T. Stephenson</b>   | 14. MOTHER'S MAIDEN NAME<br><b>Caroline Jenks</b>  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><b>No</b>  | 16. SOCIAL SECURITY NO.<br><b>None</b>   | 17. INFORMANT<br><b>Helen D. Stephenson, Port Deposit, Md.</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Aortic &amp; Mitral Valvulitis</b><br><b>600.0</b> DUE TO <b>Congestive Failure - Chronic Pyelonephritis -</b><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <b>Chronic Pyelonephritis -</b><br>(c) <b>Chronic Pyelonephritis -</b> | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months</b><br><b>2 years</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><b>Multiple Gallstones - in Common duct</b>  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>9:50</b> a.m.<br>p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |
| 20f. (City or town)<br><b>Port Deposit, Md.</b>   | (County)<br><b>MD</b>  | (State)<br><b>MD</b>   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>May 30, 1961</b> to <b>July 1, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 1 - 1961</b> , and that death occurred at <b>9:50 A.M.</b> from the causes and on the date stated above   | 22a. SIGNATURE<br><b>Clarence I. Benson</b> M.D.   | 22b. DATE SIGNED<br><b>July 3 - 1961</b>   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Clarence I. Benson</b>   | 22d. ADDRESS<br><b>Port Deposit, Md.</b>   |  |
| 23a. BURIAL, CREMATION, or other disposition (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>7-5-1961</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hopewell Cemetery</b>   |
| 23d. LOCATION (City, town or county)<br><b>Port Deposit, Md. Rural</b>  | (State)<br><b>MD</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Lee A. Patterson &amp; Son</b>   | ADDRESS<br><b>Perryville, Md.</b>  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 5 '61</b>   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles S. Thomas</b>  |  |  |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

650

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HOUSE WORK

OWS 1000

None

Helena D. Stephenson, Fort Deposit, Ala.

[illegible]

POTTYVILLE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3074

## CERTIFICATE OF DEATH

Reg. Dist. No. 08067

|   |                                     |  |   |
|---|-------------------------------------|--|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Harford</b> <b>MARYLAND</b>  |                                     | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bel Air</b>  |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bel Air</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>2 North Kelly Ave.</b>   |                                     | d. STREET ADDRESS<br><b>2 N. Kelly Ave.</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |  |   |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First Middle Last<br><b>Jackson Levi Strickland</b>   |                                     | <b>4. DATE OF DEATH</b><br>Month Day Year<br><b>July 25, 1961</b>  |   |
| <b>5. SEX</b><br><b>M</b>   | <b>6. COLOR OR RACE</b><br><b>W</b> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><b>August 25, 1874</b>     |
| <b>9. AGE</b> (In years last birthday)<br><b>86</b> yrs.  |                                     | <b>10. IF UNDER 1 YEAR</b><br>Months Days Hours Min.   | <b>11. IF UNDER 24 HRS.</b><br>Months Days Hours Min. |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>   |                                     | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>Agriculture</b>   |   |
| <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>North Carolina</b>   |                                     | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>   |   |
| <b>13. FATHER'S NAME</b><br><b>Calvin C. Strickland</b>   |                                     | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Mary Perry</b>   |   |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                     | <b>16. SOCIAL SECURITY NO.</b><br><b>240-01-3978</b>   |   |
| <b>17. INFORMANT</b> (Daughter)<br><b>Mrs. Peter Rakalitis</b>  |                                     | <b>Address</b><br><b>2 N. Kelly Ave. Bel Air, Md.</b>  |   |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Cachexia &amp; Obstruction of Bowel</b><br>DUE TO <b>177X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CARCINOMA PROSTATE WITH METASTASES</b><br>DUE TO <b>TO BLADDER, BOWEL, LUNG, VERTEBRAE</b><br>(c) <b>OVER 1 YR</b> |                                     |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTHRITIS, ARTERIO SCLEROSIS</b>   |                                     |  |   |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     |  |   |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>   |                                     | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br>_____   |   |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a. m. _____ p. m. _____ 19____  |                                     | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br>_____  |                                     | <b>20f. (City or town)</b> _____ (County) _____ (State) _____  |   |
| <b>21. I certify that I attended the deceased from</b> <b>July 1</b> , 19 <b>54</b> , <b>to</b> <b>July 25</b> , 19 <b>61</b> , <b>that I last saw the deceased alive on</b> <b>July 25</b> , 19 <b>61</b> , <b>and that death occurred at</b> <b>8:35 P.M.</b> , <b>from the causes and on the date stated above.</b><br><b>ADDRESS</b> (Street, city or town, state) _____ <b>DATE SIGNED</b> _____   |                                     |  |   |
| <b>ACTUAL SIGNATURE</b> <b>Philip W. Heuman</b> M.D. <b>207 Hickory Ave</b>   |                                     | <b>July 26, 1961</b>   |   |
| <b>PHYSICIAN'S NAME</b> (Type) <b>PHILIP W. HEUMAN, M.D. Bel Air, Md.</b>   |                                     |  |   |
| <b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>Burial</b>   |                                     | <b>22b. DATE</b> <b>July 28, 1961</b>  |   |
| <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><b>Bel Air Memorial Gardens</b>  |                                     | <b>22d. LOCATION</b> (City, town, or county) <b>Bel Air Harf. Co., Md.</b> (State) _____   |   |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>W. Broadway &amp; Williams</b><br><b>Bel Air, Maryland</b>  |                                     | <b>24a. REC'D BY REGISTRAR</b><br><b>DATE</b> <b>JUL 27 '61</b>  |   |
| <b>24b. REGISTRAR'S SIGNATURE</b><br><b>Arthur S. Kraus</b>   |                                     |  |   |

(Joseph W. Foster)

THE UNIVERSITY OF CHICAGO



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8075 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08068

|  |                                     |  |  |
|--|-------------------------------------|--|--|
| 1. PLACE OF DEATH<br>e. COUNTY <b>HARFORD</b><br>MARYLAND  |                                     | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>                     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BEL AIR</b>   |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bel - Air</b>   |  |
| c. LENGTH OF STAY IN 1b<br><b>about 40 yrs.</b>  |                                     | 32   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>13 W. LEE ST.</b>   |                                     | d. STREET ADDRESS<br><b>13 W. Lee St</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LEWIS W.</b> Middle <b>TAYLOR</b> Last <b>TAYLOR</b>   |                                     | 4. DATE OF DEATH <b>JULY 14 1961</b>   |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>NEGRO</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>December 12, 1893</b>                                 |
| 9. AGE (In years last birthday)<br><b>67 yrs.</b>  |                                     | 10. IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>2</b>   |  |
| 11. IF UNDER 24 HRS.<br>Hours <b>7</b> Min. <b>2</b>   |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Classified Laborer</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Berry Chemical Center</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Calvary, Maryland</b>  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>William A. Taylor</b>  |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Susie Johnson</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><b>yes World War I</b>  |                                     | 16. SOCIAL SECURITY NO.<br><b>212-01-4050A</b>   |  |
| 17. INFORMANT<br><b>Mrs. Connie Eldon</b>  |                                     | Address <b>320 Market St</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <b>HYPERTENSIVE ARTERIOSCLEROTIC</b><br>(c) <b>CARDIO VASCULAR DISEASE</b><br><b>CORONARY</b>   |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>SUDDEN</b><br><b>OVER 3 YRS</b><br><b>3 YRS AGO</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                     |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>a.m.</b> <b>19</b><br>p.m.  |                                     | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                     | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                     |  |  |
| CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                                     | DATE SIGNED  |  |
| ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                                     | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |
| ACTUAL SIGNATURE <b>Philip W. Heuman</b> M.D.  |                                     | 307 HICKORY <b>JULY 15, 1961</b>   |  |
| EXAMINER'S NAME (Type) <b>PHILIP W. HEUMAN M.D.</b>  |                                     | Address (Street, city, town, or county) <b>BEL AIR, Md</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>7/19/61</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>  | 22d. LOCATION (City, town, or country) (State)<br><b>Baltimore City, Md.</b> |
| 23. FUNERAL DIRECTOR<br><b>Elmer E. Bulluck</b>  |                                     | 24a. REC'D BY REGISTRAR<br><b>JUL 19 1961</b>  |  |
| ADDRESS<br><b>Harve de Grace, Md</b>   |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>Walter S. Francis</b>   |  |

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 8076 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08069

FOR STATE  
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>HARFORD</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>               |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Fallston (Rural)</b>  |  |   |  | c. LENGTH OF STAY IN lb<br><b>2 years</b>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Hess Road</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>CARL S. THOMAS</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>25</b> Year <b>19 61</b>  |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Sept. 10, 1912</b>   |  |
| 9. AGE (In years last birthday)<br><b>48 yrs.</b>  |  | 10. IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>5</b>  |  | 11. IF UNDER 24 HRS.<br>Hours <b>50</b> Min.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Truck Driver</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Highway Dept.</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Grant, Virginia</b>                     |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |  |  |   |  |
| 13. FATHER'S NAME<br><b>Eli Thomas</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Cessie Pugh</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>219-03-6801</b>  |  | 17. INFORMANT<br><b>Mr. Kyle Thomas</b> Address <b>Conowingo Road Bel Air, Maryland</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive and Arteriosclerotic Heart Disease.</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause last. DUE TO (c)  |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Hour <b>a.m.</b> p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><b>Charles S. Petty</b>  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | DATE SIGNED<br><b>7/25/61</b>   |  |
| EXAMINER'S NAME (Type)<br><b>Charles S. Petty, M.D.</b>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |   |  | 22b. DATE THEREOF<br><b>July 29, 1961</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Grant Methodist Cem.</b>                       |  |
| 22d. LOCATION (City, town, or country)<br><b>Grant, Virginia</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br><b>Jul 27 '61</b>   |  |   |  |
| 23. FUNERAL DIRECTOR<br><b>Joseph W. Foster</b>  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thomas</b>  |  |   |  |

(M)

(1)

Male

White

Age

Height

Weight

Build

Complexion

Scars

Birth

Place

Parents

Education

Occupation

Marital

Other

Operative and Anesthesiologic Heart Disease.

Charles C. Terry, M.D.

1115 E. 10th Street, Minneapolis, Minn.

Telephone 2-1111

Not a physician

8077

## CERTIFICATE OF DEATH

Reg. Dist. No. 08070

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Hartford</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>   |   | c. LENGTH OF STAY IN 1b <u>42 years</u>   |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>   |   | 32  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>323 So. Main</u>  |   | d. STREET ADDRESS <u>323 S Main St</u>  |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>ANNA MARY TOWNER</u>   |   | 4. DATE OF DEATH<br>Month Day Year<br><u>July 2 1961</u>  |   |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>White</u>             | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 24-1909</u>                                       |
| 9. AGE (In years last birthday) <u>52</u> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during normal working life, even if retired) <u>Telephone</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Chief Operator</u>   |   |
| 11. BIRTHPLACE (State or foreign country) <u>Fallston</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |   |
| 13. FATHER'S NAME <u>Jesse B Foard</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Bessie R Hitchcock</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |   | 16. SOCIAL SECURITY NO. <u>212-05-0278</u>  |   |
| 17. INFORMANT <u>BENJAMIN W TOWNER</u>  |   | Address <u>323 S Main St Bel Air, MD</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION, ACUTE</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u><br>DUE TO<br>(c) <u>CONGESTIVE FAILURE</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u><br><u>OVER 6 YRS</u> |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETES MELLITUS</u>   |   |   |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. _____ 19____   |   | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) _____ (County) _____ (State) _____  |   |
| 21. I certify that I attended the deceased from <u>DEC. 7</u> , 19 <u>55</u> to <u>JULY 2</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>JUNE 27</u> , 19 <u>61</u> , and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above.   |   |   |   |
| ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D.   |   | ADDRESS (Street, city or town, state) <u>307 Hickory Belkin, Md</u>   |   |
| PHYSICIAN'S NAME (Type) <u>PHILIP W. HEUMAN M.D.</u>  |   | DATE SIGNED <u>July 2, 1961</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   | 22b. DATE THEREOF <u>July 5/61</u>        | 22c. NAME OF CEMETERY OR CREMATORY <u>Spurlock Episcopal</u>  | 22d. LOCATION (City, town, or county) (State) <u>Perryman Hartford MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J Foster</u>   |   | ADDRESS <u>Bel Air, Md</u>  |   |
| 24a. REC'D BY REGISTRAR <u>Jul 5 '61</u>  |   | 24b. REGISTRAR'S SIGNATURE <u>Christina S. Hanna</u>  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2027

|  |  |  |                        |                   |
|--|--|--|------------------------|-------------------|
| NAME OF DECEASED<br>JAMES H. HARRIS    |  | AGE<br>45                                | SEX<br>Male            | RACE<br>White     |
| DATE OF DEATH<br>April 15, 1927        |  | TIME OF DEATH<br>10:30 AM                | PLACE OF DEATH<br>Home | CITY<br>Baltimore |
| CAUSE OF DEATH<br>Heart Disease        |  | MANNER OF DEATH<br>Natural               |                        |                   |
| SIGNATURE OF PHYSICIAN<br>J. H. HARRIS |  | SIGNATURE OF WITNESSES<br>J. H. HARRIS   |                        |                   |
| SIGNATURE OF DECEASED<br>J. H. HARRIS  |  | SIGNATURE OF NEXT OF KIN<br>J. H. HARRIS |                        |                   |
| SIGNATURE OF REGISTRAR<br>J. H. HARRIS |  | SIGNATURE OF CLERK<br>J. H. HARRIS       |                        |                   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8078  
CERTIFICATE OF DEATH

08071  
BALTIMORE

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>HARFORD</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>                     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>FALLSTON MD.</u>  |                                  | c. LENGTH OF STAY IN 1b<br><u>LIFE</u>   |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>FALLSTON MD.</u>  |                                  | d. STREET ADDRESS<br><u>FALLSTON MD. HARFORD CO.</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>WALTER</u> Middle <u>WATTERS</u> Last  |                                  | 4. DATE OF DEATH<br>Month <u>JULY</u> Day <u>10</u> Year <u>1961</u>   |   |
| 5. SEX<br><u>MALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><u>NOV 14, 1864</u> |
| 9. AGE (In years lost birthday) <u>96</u> yrs.   |                                  | IF UNDER 1 YEAR: Months <u>96</u> Days <u>96</u> Hours <u>96</u> Min. <u>96</u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>FARMER</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>FARMER</u>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>HARFORD CO MD</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA.</u>  |   |
| 13. FATHER'S NAME<br><u>ROBERT WATTERS</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>HANN</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><u>313-38-6674</u>  |   |
| 17. INFORMANT<br><u>W ARCHER WATTERS</u>   |                                  | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Insufficiency</u><br>DUE TO <u>Edema</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Brugum of the foot</u><br>DUE TO (c) <u>Brugum of the foot</u> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 wks</u><br><u>7 yrs</u><br><u>4 wks</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>o. m.</u> <u>19</u><br>p. m.   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1933</u> to <u>July 8, 1961</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.  |                                  |  |   |
| 22a. SIGNATURE<br><u>Walter M. Hammond</u> M.D.  |                                  | 22b. DATE SIGNED   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Walter M. Hammond</u>   |                                  | 22d. ADDRESS<br><u>Baltimore Md</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |                                  | 23b. DATE THEREOF<br><u>JULY 13, 1961</u>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>ROCKY REST SPANER FAMILY</u>  |                                  | 23d. LOCATION (City, town, or county) (State)<br><u>BALTIMORE MD</u>   |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Sassahn Funeral Home</u>  |                                  | 25a. REC'D BY REGISTRAR<br><u>DATE JUL 13 '61</u>  |   |
| ADDRESS<br><u>7401 Belair Rd #6</u>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Hines</u>   |   |

(M)

2028

CERTIFICATE OF DEATH

1. Name of Deceased: WALTER W. WATERS  
2. Date of Death: July 10, 1954  
3. Place of Death: Home  
4. Cause of Death: Heart Disease  
5. Age at Death: 78  
6. Sex: Male  
7. Race: White  
8. Marital Status: Married  
9. Occupation: Retired  
10. Signature of Physician: W. W. Waters  
11. Signature of Registrar: W. W. Waters  
12. Date of Registration: July 10, 1954

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

I

MEDICAL CERTIFICATION

8079  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08072

|   |                           |  |                                      |  |   |   |  |
|---|---------------------------|--|--------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> MARYLAND  |                           |  |                                      | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>e. STATE <u>md</u> b. COUNTY <u>Harford</u> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>   |                           | c. LENGTH OF STAY IN lb  |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>                                      |   | d. STREET ADDRESS <u>1 n s route 1</u>    |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ns route 1</u>  |                           |  |                                      | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |   |   |  |
| 3. NAME OF DECEASED (Type or print) First <u>Howard T</u> Middle <u>Weil</u> Last <u>Weil</u>   |                           |  |                                      | 4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1961</u>   |   |   |  |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 9, 1895</u> | 9. AGE (In years last birthday) <u>66</u> yrs.   | IF UNDER 24 HRS. (Months Days Hours Min.) |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>Palmer</u>  |                                      | 11. BIRTHPLACE (State or foreign country) <u>Baltimore md</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |
| 13. FATHER'S NAME <u>Wm H. Weil</u>   |                           | 14. MOTHER'S MAIDEN NAME <u>Cora Thompson</u>  |                                      | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>  |   |   |  |
| 16. SOCIAL SECURITY NO. <u>314-095225</u>   |                           | 17. INFORMANT <u>Sabel Thompson</u>  |                                      | Address <u>Bel air md RD</u>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic C disease</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c)<br>422.1  |                           |  |                                      | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           |  |                                      |  |   |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                           | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)      |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                           |  |                                      |  |   |   |  |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u>   |                           |  |                                      | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air md.</u>   |   |   |  |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>  |                           |  |                                      | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-8-61</u>  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |                           |  |                                      | 22b. DATE THEREOF  |   | 22c. NAME OF CEMETERY OR CREMATORY        |  |
| <u>Burial July 12, 1961</u>   |                           |  |                                      | <u>July 12, 1961</u>   |   | <u>Park Road Cm 5510 Harbor Road</u>      |  |
| 23. FUNERAL DIRECTOR <u>H. S. Bailey</u>  |                           |  |                                      | ADDRESS <u>Baltimore Md</u>  |   | 24a. REC'D BY REGISTRAR <u>Jul 12 '61</u> |  |
|   |                           |  |                                      | 24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hines</u>  |   |   |  |

M

Return  
to  
the  
214-07-22  
Baltimore  
A

W. B. Coley  
July 10, 1914  
214-07-22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled in by the funeral director. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

8080

08073

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HARFORD</b><br>c. LENGTH OF STAY IN 1b <b>DOA</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HARFORD Memorial Hosp.</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Liberty Grove, Rural</b><br>d. STREET ADDRESS<br>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <b>G. Norwood</b> First Middle Last<br>4. DATE OF DEATH <b>July 7 1961</b> Month Day Year  |  | 5. SEX <b>MALE</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>Aug. 20, 1891</b> 9. AGE (In years last birthday) <b>69</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Owner</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>  |  |
| 13. FATHER'S NAME <b>James Williams</b>  |  | 14. MOTHER'S MAIDEN NAME <b>Mary Mason</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO. <b>218-18-4601</b> 17. INFORMANT <b>Margaret Williams, Liberty Grove, Md.</b> Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis bilateral</b><br>002x DUE TO (b) <b>Erosion of Cranium into long vessel 1 hr.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>with massive hemorrhage, selected</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work<br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June 30</b> , 1961, to <b>July 2</b> , 1961, that (I) (we) last saw the deceased alive on <b>July 7</b> , 1961, and that death occurred at <b>1:15</b> M, from the causes and on the date stated above.   |  |   |  |
| 22a. SIGNATURE <b>G.H. Richards Jr.</b> M.D.   |  | 22b. DATE SIGNED <b>7/7/61</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>G.H. Richards Jr.</b>  |  | 22d. ADDRESS <b>Port Deposit, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REINTERMENT (Specify)  |  | 23b. DATE THEREOF <b>7-10-1961</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham</b>  |  | 23d. LOCATION (City, town or county) (State) <b>Colona, Md. Rural</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Peterson &amp; Son, Perryville, Md.</b> ADDRESS   |  | 25a. REC'D BY REGISTRAR <b>JUL 10 '61</b> DATE<br>25b. REGISTRAR'S SIGNATURE <b>Arthur E. Knaus</b>   |  |

(M)

2000

Liberty Grove, Rural

Liberty Grove, Rural

Liberty Grove, Rural

Liberty Grove, Rural

(I)

Liberty Grove, Rural

Liberty Grove, Rural

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

8081

08074

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>HARFORD</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>DELAWARE</b> b. COUNTY |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAUCE DE GRACE</b>  |  | c. LENGTH OF STAY IN 1b <b>11 HRS</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL Hosp</b>   |  | d. STREET ADDRESS <b>53 EIKton Rd.</b>  |  |
| 3. NAME OF DECEASED (Type or print) <b>Baby Boy Keith Williams</b>  |  | 4. DATE OF DEATH <b>July 20 1961</b>  |  |
| 5. SEX <b>MALE</b>  |  | 6. COLOR OR RACE <b>WHITE</b>   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <b>July 19, 1961</b>   |  | 9. AGE (In years lost birthday) yrs. <b>11</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |
| 13. FATHER'S NAME <b>JAMES B. Williams</b>  |  | 14. MOTHER'S MAIDEN NAME <b>Betty Richardson</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>   |  | 16. SOCIAL SECURITY NO. <b>—</b>  |  |
| 17. INFORMANT <b>Hospital Records</b>   |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br>774X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYALINE MEMBRANE DISEASE</b><br>DUE TO (c) <b>PREMATURITY</b> |  | INTERVAL BETWEEN ONSET AND DEATH <b>8 HRS.</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                              |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>                      |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7:19</b> 19 <b>61</b> to <b>7:20</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>7-19</b> 19 <b>61</b> , and that death occurred at <b>2:30</b> AM, from the causes and on the date stated above.   |  |   |  |
| 22a. SIGNATURE <b>R. Norment M.D.</b>   |  | 22b. DATE SIGNED  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>RICHARD NORMENT</b>   |  | 22d. ADDRESS <b>602 SOUTH UNION AVE HAUCE DE GRACE Md</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE THEREOF <b>7-21-1961</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>FRIENDS</b>   |  | 23d. LOCATION (City, town, or county) (State) <b>Calvert, Cecil Co</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b>   |  | 25a. REC'D BY REGISTRAR <b>North East Md</b>  |  |
| 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>   |  | DATE <b>JUL 24 '61</b>  |  |

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(M)  
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1901

CERTIFICATE OF DEATH

1901

James B. Williams  
Male  
White  
Born July 19, 1861  
New York  
Residence 23 E. 10th St.  
New York  
Cause of Death  
Hospital  
Physician  
Buried 1-21-01  
Burial place  
Buried 1-21-01  
Burial place

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VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
08075

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|--|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>HARFORD</b> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>               |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HARRE DE GRACE</b>   |                           | c. LENGTH OF STAY IN 1b <b>20 DAYS</b>   |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL HOSPITAL</b>  |                           | d. STREET ADDRESS <b>DARLINGTON</b>  |                                      |
| 3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNABELLE E. WILSON</b>   |                           | 4. DATE OF DEATH Month Day Year <b>JULY 28 1961</b>  |                                      |
| 5. SEX <b>F</b>  | 6. COLOR OR RACE <b>C</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Nov. 8, 1895</b> |
| 9. AGE (In years lost birthday) <b>65 yrs.</b>   |                           | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <b>8 20</b>  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY  |                                      |
| 11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>  |                           | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |                                      |
| 13. FATHER'S NAME <b>AUGUSTUS SHERWOOD</b>   |                           | 14. MOTHER'S MAIDEN NAME <b>CLARA WILLIAMS</b>   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>  |                           | 16. SOCIAL SECURITY NO. <b>213-16-1149A</b>  |                                      |
| 17. INFORMANT <b>Mr. John J. Wilson</b>  |                           | Address <b>Box # 159</b>   |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes Mellitus</b><br>DUE TO (c) <b>Hypertensive Cardio renal disease</b> |                           | INTERVAL BETWEEN ONSET AND DEATH   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>  |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                           | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <b>May 1, 1961</b> to <b>July 28, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 28, 1961</b> , and that death occurred at <b>5:40</b> A.M. from the causes and on the date stated above.   |                           |  |                                      |
| 22a. SIGNATURE <b>George T. Stansbury</b>  |                           | 22b. DATE SIGNED <b>7/29/61</b>  |                                      |
| 22c. PHYSICIAN'S NAME (Type) <b>George T. Stansbury</b>  |                           | 22d. ADDRESS <b>569 Revolution St. Harre de Grace, Md.</b>   |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                           | 23b. DATE THEREOF <b>Aug 2, 1961</b>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Berkley Cemetery</b>   |                           | 23d. LOCATION (City, town, or county) (State) <b>Darlington Md</b>   |                                      |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Elmer E. Bullenk</b>   |                           | 25a. REC'D BY REGISTRAR <b>Arthur S. Knead</b>   |                                      |
| ADDRESS <b>Harre de Grace</b>  |                           | 25b. REGISTRAR'S SIGNATURE   |                                      |
| DATE <b>AUG 3 '61</b>  |                           |  |                                      |

